MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12024 CERTIFICATE OF DEATH

	- Martin and a second					U436				
1. PLACE OF DEATH			44	2. USUAL RESIDENT	GE (Where deceased lived,	If institution: Re	esidence before admission			
Allega	anv		MARYLAND	a. STATEW. V	a	COONTT	V			
b. CITY OR TOWN	(If outside corporate li	imits, c. LE	NCTH OF STAY IN 15		outside corporate limi	ts, write RURAL	and give nearest town			
Cumber			5 Wks	Paw F	wa [°]		55-3			
	PITAL OR INSTITUTION (If not in hospital,	, give street address	d. STREET ADDRESS			e. IS RESIDENCE			
Sacred	Heart Hospi	tal		Route	#31		YES NO			
3. NAME OF DECEASED	First		Middle	Last	4. DATE OF	Month	Day Year			
(Type or print)	Thomas		G.	Arnica	DEATH	13	14 1967			
		MARRIED NI	EVER MARRIED	8. DATE OF BIRTH	9. AGE (In)		Days Hours Min.			
Male	White ,	WIDOWED	DIVORCED	5/10/13	53	rrs.	Days Rouis Min.			
10a. USUAL OCCUPATION	ON (Cive kind of work don ng life, even if retired)	e 10b. KIND OF	BUSINESS OR	11. BIRTHPLACE (C	ounty & State, or foreign o	ountry) 12. Cl	TIZEN OF WHAT			
	Mfg. Co.		en Cabin	ets Paw Paw	r, W. Va.	000	USA			
13. FATHER'S NAME	MIE. OO.	1 111 0011	CII OUDIII	14. MOTHER'S MAIL		1				
Alber	t F. Arnica	a.		Annie M	I. Leach					
15. WAS DECEASED EV	VER IN U.S. ARMED FORCE	ES? 16. SOCIAL	SECURITY NO. 17	INFORMANT John	n Arnica,	Paw Pav	v. W. Va.			
NO	(If yes give war or dates of ser	213-1	0-9683	patient's ch	art		,			
	EATH [Enter only one ca	ause per line for	(a), (b), and (c).]	<u></u>	. 7	1	INTERVAL BETWEEN			
	TH WAS CAUSED BY:	11 10	inous	Pericardi	ites		ONSET AND DEATH			
5913	-918 Immediate Gause (a)									
Conditions, If a	nv. which \	acul	e Hlas	nerulone	phritis	R.	5 weeks			
gave rise to l	Immediate (- ,	7	-					
	cause (a), stating the DUE TO									
		CONTRIBUTING	O DEATH BUT NOT RE	LATED TO THE TERMINAL I	DISEASE CONDITION CIV	EN IN PART 1(a)	19. WAS AUTOPSY			
Ex Promi	24	01 4	_	safe.	etage 15		PERFORMED?			
208 ACCIDENT V	PREVIOUS Meletrelitoring Prillemalic At right 15 YES TO NO [] 200. ACCIDENT WAS UNDERLYING 200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
PARTII OTHERSI PLEVE 20a. ACCIDENT OR CONTRIBUTION (IF EITHER, NOT	IG CAUSE OF DEATH	2001 20011	se nay mount of	OMMEDI (Ello) III.	,2,,					
S 20c. TIME OF IN	NJURY Month, Day, Yea	r 20d. INJURY	OCCURRED 20e. P	ACE OF INJURY (Home, for	arm, 20f. (City or to	wn) (Cour	nty) (State)			
20c. TIME OF IN Hour a.m.		While No	ot While	tory, street, office bldg., e	:(0.)					
21 certify	21. I certify that (I) (this hospital) attended the deceased from MARCH 9, 1967, to MARCHIY, 1967, that (I) (we) last									
saw the deci	saw the deceased alive on MARCH 13 1967, and that death occurred M. from the causes and on the date stated above.									
	22a. SIGNATURE 22b. DATE SIGNED									
KIC	hard Sc	hindl	er M.D.	.D. PHYS.	MED. STAFF DIRECTOR PHYS.	D 3-	14-67			
22c. PHYSICIAN NAME (Type		1 0 1	37	22d. ADDRESS						
MANUE (13)	D _r . Richa	ard Schin	laler	69 Gre	ene St., Cu	mberland	, Md.			
23a. BURIAL, CREMA	TION, 23b. DATE THE		NAME OF CEMETE		23d. LOCATION (C		inty) (State)			
REMOVAL (Spec		7	Camp Hil	l Cem.	Daw Pav		. Va.			
24. FUNERAL DIREC	Ster &	V-M-	ADDRESS	25a. RE	C'D BY REGISTRAR 25	/1 /m //	mi 4.			
Johnson	Funeral H	omes Be	rke lev	Spgs. Whate V	MAR & U 1967	your	res Judge			
V V - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	7 11									

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items CERTIFICATE OF DEATH 02932 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY **b** COUNTY Allegany Allegany MARYLAND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Frostburg in by Lonaconing e. IS RESIDENCE ON A FARM? remove carban papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS the attending physician and campletely filled sit permit. Then please remove carban pape Miners Hospital Main Street NO Se 3. NAME OF Middle Lost 4. DATE Month Year Doy DECEASED 19 67 Marie E. Baumann March Type or print DEATH S. SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours White DIVORCED Female 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) INDUSTRY COUNTRY? Operator of 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles Kaefer Eve B. Lear Lehr 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give wor or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Anthony Keafer Rt 1. Frostburg, Md. cremation. INTERVAL BETWEEN Brother CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) burial-transit PART I, DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO burial. Canditians, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying couse be retained by the haspital ar attending DIRECTOR: After this certificate has been far use as the WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER Dept. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour o.m. factory, street, office bldg., etc.) Not While at work 19 67 to 3/28 , 1967 that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from 3/24 19 (a), and that death accurred at 8 500 M, from causes and an the date stated above. saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR TO HOSPITAL (Poge 4 may b 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, shauld b 23h. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 230. BURIAL, CREMATION, BREMOVAL (Specify) 67 Md Oak Hill Cemeterv Lonaconing 250. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Michaeles Judan George Eichhorn Lonaconing. Md.

IN POSTAGE TWO SETS IN COMMENT AND A SET OF SETS OF SE ASPSA variety City 100 to 1000 form STORES OF STREET Appendix and the second detailed it secretors West Thought Shipper I con drail it ma .b., ruming will gar to test will day to We are the second of the second second to be the second of Breshe Habiliyan Inch contins, let. 11151 Smil

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

	02933			CERTIFI	CAH	E OF DEATH	1	1)2	925				
1.	PLACE OF DEAT	1				2. USUAL RESIDEN	E (Where de			esidence	before a	dmission)	
	Allegany			MARY	LANO	a. STATE Mar	vland	b. cour		Allegany			
		N (If outside corpora and give nearest toy	te limits,	c. LENGTH OF STAY		c. CITY OR TOWN (IF		porate limits, wr				st town)	
	Cumi	and give nearest too berland	vn)	50 years	s	T.a.T	/al.e			1	0/1	1	
-		SPITAL OR INSTITUTION	ON (If not in ho			d. STREET ADDRESS	-200			0	. IS RES	DENCE	
	D. O.	A. Sacred	Heart	Hospital		R.D.#1	Gram	leck Rd.		Y	ES .	FARM?	
3.		F	irst	Middle		Last	4. DATE	Monti	1	Oay	Ye	ar	
	(Type or print)	Joh	n	М.	Be	ckman	DF DEATI			14		67	
5.	SEX	6. COLOR OR RACE	7. MARRIEO	NEVER MARRIE		B. DATE OF BIRTH	r.5 9.	AGE (In years last birthday)	IF UNDER				
	Male	White	WIOOWED	OIVORCE		4/93	893	73 yrs.	Months	Days	Hours	Min.	
10	. USUAL OCCUPAT	ION (Give kind of work ing life, even if retire	done 10b. Kil	ND OF BUSINESS OR		11. BIRTHPLACE (C	ounty & State) 12. CI	TIZEN C	F WHAT	1	
1	lachinis	t retired		ailroad		Swant	on, Mo	l •	00	ORTER		SA	
13	. FATHER'S NAM	IE .				14. MOTHER'S MAIO	EN NAME						
	John	A. Beckma	n			Mary Mc	Fadde	en					
15	. WAS DECEASED	EVER IN U.S. ARMED FO	DRCES? 16. S	SOCIAL SECURITYNO	. 17.	INFORMANT		Addre	SS				
(1	yes II	(If yes give war or dates	or service)			patient's	char	t					
-		OEATH [Enter only or	ne cause per lir	ne for (a), (b), and (c).]					INTER	RVAL BE	TWEEN	
	PART 1. DEATH WAS CAUSED BY-									ONSET AND DEATH			
	42 A / IMMEDIATE CAUSE (a) Coronary occlusion												
	Conditions, If any, which \ (b)								2 -	2 *****			
	gave rise to immediate									4.00			
	cause (a), stating the OUE TO underlying cause last. (c) Coronary Thaufficiency								2 *****				
NO			ONSCONTRIBUT	TING TO DEATH BUT N	OTRELA	TED TO THE TERMINAL	DISEASE CON	DITION GIVEN IN	PART 1(a)	19.	WAS AL	UTOPSY	
CERTIFICATION				NT						YES	PERFOR	NO 配	
E	20a. ACCIDENT	WAS UNDERLYING	20b. D	None :	RY DCCU	RRED. (Enter nature o	f injury in P	art I or Part II o	f Item 18.			17-1	
CER	OR CONTRIBUTI	ING CAUSE OF DEATIFY MEDICAL EXAMI	(TH NER)										
		INJURY Month, Oay,		JURY OCCURRED 12	20e. PDA	CE OF INJURY (Home, f	arm, 20f.	(City or town)	(Cou	nty)	(State)	
MEDICAL	Hour a.i	m.	While	Not While	facto	ry, street, office bldg., e	rtc.)						
Z	p,t				. 1/-	- 30 1	26E 40	March 14	106	7 .1.	-A (1) 6	una) Inol	
	21. I certif	y that (I) (this hos ceased alive on M	pital) attende	the deceased to	rometa	death occurred at							
	22a. SIGNATU		1	19 71 , 8	inu tilat	death occorred at		Our rue canaca	22b. 0			1 80016.	
	- Lan	of some	elenan	1 ma	M.0	ATTENOING #	MEO. DIRECTOR	STAFF PHYS.	37	7-67	,		
1	226. PHYSICIA	IN'S		1	м.0	1 22d. AOORESS							
-	NAME (T	ppe) Dr. J.	ames P.	Hallinan		140	Bedfor	d St. Cun	berla	nd,	Md.		
23		MATION, 23b. OATE		23c. NAME OF CI	EMETERY	OR CREMATORY	23d. L	OCATION (City, t	own or cor	unty)	(S	tate)	
	REMOVAL (So Burial	fullan	17,196			orial Park		berland			gan	y	
24	FUNERAL DIRI		-1,7-7-	AOORESS			7	STRAR 25b. R	EGISTRAR'	S SIGN	ATURE		
	James	F. Scarne	114 C1	umherland	M a	MAR	2 3 19	167 RCL	iarles	Jus	HE		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the heneral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. after death O HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours Page 4 may be retained by the hospital or attending physician.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE DESCRIPTION OF DEATH

1.	PLACE OF DEATH a. CDUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE b. COUNTY						
	AT.T.EGATTV MARYLANO	MARYLAND ALLEGANY						
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. CITY DR TOWN (if outside corporate limits, write RURAL	and give hearest town)				
_	CIMBERIAND 27 bms	CHMRERI	ANT	01-1				
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?				
_	SACRED HEART HOSPITAL	31), BROADWAY YES NO.K						
3.	NAME OF First Middle DECEASED	Last	4. DATE Month	Oay Year				
	(Type or print) TONE & WARNEY ME	LANK	DEATH 3/6/67	19				
5.	SEX 6. CDLOR OR RACE 7. MARRIED X NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years IF UNDER	1 YEAR IF UNDER 24 HRS.				
	FEMALE WHITE WIDOWEO DIVORCEO	12/12/14	last birthday) Months	Oays Hours Min.				
10:	I. USUAL DCCUPATION (Give kind of workdone IDD. KIND OF BUSINESS DR INDUSTRY INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. C	ITIZEN OF WHAT				
Uu,	Ing most of working life, even if retired) Housewife Own Home	Parsons	W. Va.	USA USA				
13	FATHER'S NAME	14. MOTHER'S MAI		- JOH				
	Freeman Kellar	Effie	D voi e					
15	WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17	INFORMANT	Address					
{Y	is, No, or unknown) (If yes give war or dates of service)							
_	no l	PT'S CHART						
	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND OEATH				
	PART I. OEATH WAS CAUSEO BY: IMMEDIATE CAUSE (a) MVocardial Fail	ure		2 days				
	£27/							
	Conditions, If any, which (b) Bronchopneumoni	5day:						
gave rise to immediate Droffertophie unforted								
	united the state had been been been been been been been bee							
underlying cause last.) (c) Emphysema acute, bilateral 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOP								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) chronic bronchitis 2Da. ACCIDENT WAS UNDERLYING DEATH OF CONTRIBUTING DEACHED. (Enter nature of Injury In Part I or Part II of Item 18.) DR CONTRIBUTING DEACHED. (Enter nature of Injury In Part I or Part II of Item 18.) None								
H	2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCU	RREO. (Enter nature o	of injury in Part I or Part II of Item 18.)				
E E	2Dc. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 2De. PLA	CE DF INJURY (Home, 1	farm, 20f. (City or town) (Cou	inty) (State)				
MEDICAL	Will Will Will will will will will will	ry, street, office bldg.,	etc.)					
Σ		mah E	1967 to March 6, 196	7				
	21. 1 certify that (I) (this hospital) attended the deceased from Ma	FUL D.	15-AM	I, that (I) (we) last				
		death occurred at	MA From the causes and on the	ne date stated addve.				
	22a. SIGNATURE	ATTENOING CON						
	med . Naccenary M.C.	D. PHYS. 世	MEO. OIRECTOR PHYS. 13-7-	67				
	PHYSICIAN'S DR. HALLINAN_James P. Halli	nan M. D.	140 Bedford St., Cumb	erland, Md.				
238	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY		23d. LOCATION (City, town or cou					
	REMOVAL (Specify)							
	James F. Scarpelli, umberland, Md. MAR 1 4 196/ / Martin years							
_	OATE							

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Allegany MARYLAND Maryland on papers. Pages within 72 hours aft c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) o Vale La Vale d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 1050 Mational No T Highway 10 5 COMA executed within completely NAME OF Middle Month Last DECEASED car 1947 (Type or print) Boch Ruth DEATH March any event rances 5. SEX AGE (In years | IF UNDER I YEAR | IF UNDER 24 HRS. | Jast birthday) | Months | Days | Hours | Min. 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED WIDOWED F DIVORCED Female Ξ. 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT please I physician aw requires that the death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? Cumberland, Maryland U.S.A. ouse wite 13. FATHER'S NAME MOTHER'S MAIDEN NAME Гепточа Mary C. Miller erom e 15. WAS DECEASED EVER YN U.S. ARMED FORCES! INFORMANT / 16. SOCIAL SECURITY NO. 17. Address been signed by the attenthe burial-transit permit. (Yes, no. or unkown) (If yes give war or dates of service) George A. Bech a Vale, maryland INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) the hospital or attending physician. Joron ary occlusion uly DUE TO Conditions, if any, which (b) oselorotic Loont gave rise to immediate DUE TO cause (a), stating the prior 1 underlying cause last. as CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED WAS AUTOPSY for use Health p PERFORMED? this certificate NO [YES T 208. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) detached for the Dept. of I MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) (State) be de State Hour a.m. After While Not While 19 at work at work p.m. TO FUNERAL DIRECTOR: Af director, page 3 should be should be filed with the S be retained Ф , 19.67, to [er]] , 19.37, that (i) (we) last 21. I certify that (I) (this hospital) attended the deceased from Isn 19 19 F. 7. and that death occurred at Q AM; from the causes and on the date stated above. the deceased alive on ware 22b. DATE SIGNED 22a_ SIGNATURE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. TO Host Page 4 may 1 M.D. ADDRESS PHYSICIAN'S 22d. NAME (Type) Bedford BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23a. ADDRESS REC'D BY REGISTRAR 25b. 196 VR A15 (4) 15M 4-64

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	" _	4	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYL	AND
J.	Ann :		02937 CERTIFICATE OF DEATH 0292	29
	funeral and 2	汀	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence	before admissio
	e fi		ALLEGANY COUNTY MARYLAND "a. STATE ALLEGAN" ALLEGAN	4
ą	by the final Pages 1 mrs after	ľ	b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY DR TOWN (If outside corporate limits, write RURAL and give	
	in by Pa		CUMBERLAND, MD. LIFE CUMBERLAND, MD.	
	ed i	- 1		. IS RESIDENCE DN A FARM?
	Into law requires that the deadth certificate be executed within 24 hours after beauty or attending physician. Late has been signed by the attending physician and completely filled in by the funeral r use as the burial-transit permit. Then please carbon papers. Pages 1 and 2 eaith prior to burial, cremation, or removal, and it any eyent, within 72 hours after death	72	SACRED HEART HOSPITAL 900 SEATON DRIVE 608 N. MECHANIC ST.	ES NO
1	noletely carbon phi, with		3. NAME OF First Middle Last 4. DATE Month Day DECEASED	Year
	Post in		(Type or print) CLAKA MABEL BRADLEY DEATH MARCH; 30	
4			5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR Jast Dirthday) Months Days 20	Hours Mir
	sician lease and in		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR LIL BIRTHPLACE (County & State, or foreign country) 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN (COUNTRY) WHAT NONE GREAT CAPON WEST VA USA	P WHAT
	ysic ysic plea plea	l a		
	oval		13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
	remines planting plan	-	JOSEPH SNYDER ALICE MM TRUE	
Ė	oeatri cerrilicate be ne attending physician permit. Then please tion, or removal, and h		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no No unkown) (If yes give war or dates of service) 217-10-1338 HOSPITAL CHART-SACRED HEART HOSPITAL	TA1
-	dea ne a peri	-	217 TO 1550 HOST THE CHART SHORED HEART 11057 T	
	ar the dearian. d by the arranskt perr	- 1	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: CONGESTIVE HEART FAILURE	WAL BETWEEN
-	law requires that the attending physician. I has been signed by the as the burial-transit h prior to burial, creman		IMMEDIATE CAUSE (a)	MEENS
-	s the		Sanditions if any which DUE TO MRTERIOSCLEROTIC CARDIO-VASCULAR DISEASE 5	YEARS
	an s		Conditions, if any, which (b)	
	required in ding per the the or to		cause (a), stating the DUE TO	
	taw re ttendii has bt as th prior			WAS AUTOPS
	l: The rad al or at ficate be for use Health	2	HRONIC BRONCHITIS. UREMIA	PERFORMED?
				<u></u>
			20a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) GR CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	e de		3 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County)	(State)
	After de		20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, Hour a.m. White Not While at work at wor	
	retained by ECTOR: After 3 should be with the State	l l	21. I certify that (I) (this hospital) attended the deceased from 2 - 16 , 19 65, to 3 - 30 , 1967, the	at (I) (we) la
	tained tained TOR: / hould h the		saw the deceased alive on 3-30 197, and that death occurred at 2 P M, from the causes and on the date	
	wit with		22a. SIGNATURE /) 22b. DATE SIG	
	AL DK ALIEND lay be retained L DIRECTOR: y page 3 should filed with the		M.D. ATTENDING MED. STAFF DIRECTOR PHYS. 3-30-	67
		1	PHYSICIAN'S NAME (Type) RALPH W. BALLIN M.D. 62 GREENE ST. CUMBERLAND, MD. 21502	
	o nosrii Page 4 m o runera director, should be	1		(State)
	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) 4-1-67 Zion Memorial Park Oumberland Maryland	(360.0)
	10	1	24 FINERAL DIRECTOR ADDRESS 1 250, REGISTRAR 250, REGISTRAR 3 SIGN	ATURE
	VR AI5 (4)	4	James F. Scarpelli Cumberland, Md. APR 5 1967 gCharles Ju	age.

127 G . 1 1 .



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STA PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before odmission) a. COUNTY a. STATE b. COUNTY Allegany Maryland Allegany deoth. MARYLAND 2, and 3 to PM3. Pog b City OR TOWN (If outside carparate limits LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Cumberland 30 years Cumberlandd NAME OF HOSPITAL OR INSTITUTION (I not in haspita, a ve street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? hours Item 18. Give Pages 1, Office along with form Sacred Heart Hospital E Stote | 701 Louisiana Ave. YES ND X This certificate should be executed within 24 hours ofter deoth NAME OF First Middle Lost 4 DATE Month Dov DECEASED 19 67 with The March 21 Robert Earl Brannon (Type or pant) DEATH S. SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9 AGE (in years F UNDER 1 YEAR IF UNDER 24 HRS 7 MARR ED **NEVER MARRIED** last birthday) Nov. 25, 1896 Male White WIDOWED DO DIVORCED 10a JSUAL DCCUPATION (G ve kind of work dane during most of working life, even if retured) Retired Machinist 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Textile _ Mt. Savage, Md. word "pending" in pericil in the Chief Medical Examiner's USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME .= John W. Brannon Elizabeth Farrell File and IS WAS DECEASED EVER IN U.S. ARMED FDRCES?
(Yes, na, or unknown) (If yes give war ar dates at service) 16. SDCIAL SECURITY ND. 17. INFORMANT or removal, Mr. Eugene Brannon, Washington, D. C. ves War 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN Days PART I. DEATH WAS CAUSED BY Atelectasis of lungs, bilateral IMMEDIATE CAUSE (a) the word cremotion, DUE TO Embolism Pulmonary Days Conditions, fany, which gove rise to immediate cause (a), DUE TO stoting the underlying cause 0 Multiple Injuries 70 Days buriol, o last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? 0 200 EXTERNAL CAUSE WAS PR MARY OF CONTRIBUTING designated agent, prior 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) should Driver of Auto involved in accident CAUSE OF DEATH 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or tawn) 20c T-ME OF INJURY Month, Doy, Year (County) Hour a.m. Not While factory, street, office bldg., etc.) moy be retained for your FUNERAL DIRECTOR: Page at wark at wark 21. I certify that I took charge of the remains described obove, held an Autapsy X, Inspection X, Inquiry X, and in my opinion death resulted fram-Natural causes , Accident X, Suicide , Homicide , Undetermined manner the funeral director. CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO FUNE. Health or it TO DEPUTY March 21, 1967 DEPUTY MEDICAL EXAMINER [34] **EXAMINER'S** Benedict Skitarelic, M.D. Address (Street, city, town, or county) Cumberland, Md. NAME (Type) 230 BUR AL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City or Town) (County) March 27,1967 Mt. Savage Cemetery Mt. Savage, Md. Allegany 24 FUNERAL DIRECTOR 25g REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURE VR A15ME (9 James F. Scarpelli, Cumberland, Md. Minney Judge MAR 27 1967



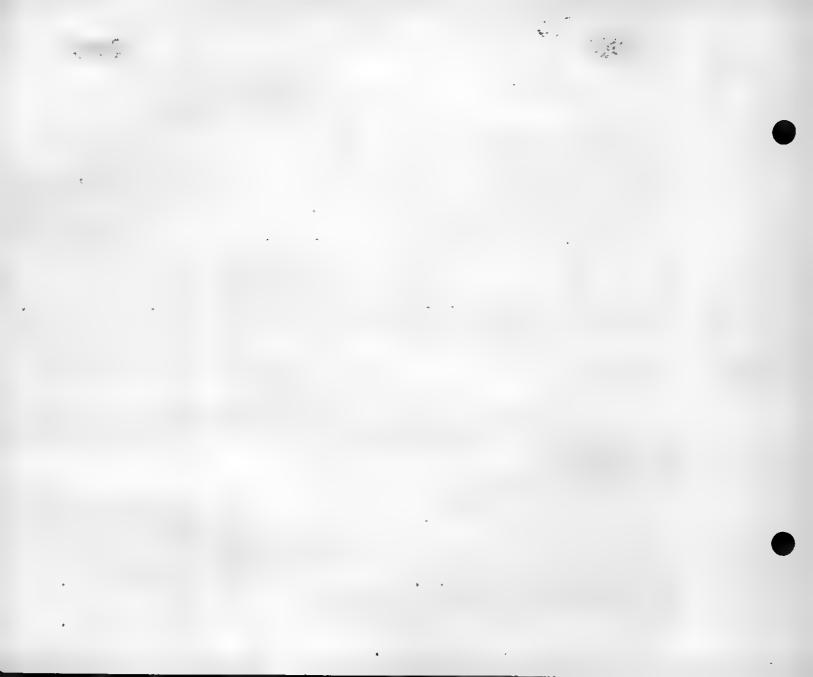
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution p COUNTY o STATE b. COUNTY Allegany West Virginia ö ofter deoth MARYLAND Hanpshire b CITY OR TOWN (if outside corporate fimits, write RURAL and give negrest town) c LENGTH OF STAY IN 16 c CTY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paw Paw Days d NAME OF HOSPITAL OR INSTITUTION (finot in hospital give street address) d STREET ADDRESS e IS RES DENCE ON A FARM? Memorial Hospital YES NO 3 NAME OF 4 DATE Month Doy Year OECEASEO OBB Brelsford March (Type or pont) DEATH 67 6 COLOR OR RACE DATE OF BIRTH 7 MARRIED DE NEVER MARRIED AGE (n years st berthday) Months White Male WIDOWED և-2-8և 11 BIRTHPLACE (Stote or foreign country) 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUS NESS OR 12 CITIZEN OF WHAT COUNTRY? West Virginia TERA 13 FATHERS NAME 14 MOTHER'S MAIDEN NAME This certificate should be executed within Benjamin Brelsford Sallie Moreland 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, no ar unknown) (If yes give war or dates of service e, writing the word "pending" in forwarded to the Chief Medical or removal, Memorial Hospital-Cumberland, Md. 0-05-63514 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY Embolism Pulmonary .MMED.ATE CAUSE (0) s a buriol-tra cremation, o DUE TO Conditions, if any, which gave Fracture of Neck of Left Femur ho Days rise to immediate couse (a), DUE TO stating the underlying couse 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GRATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) YES NO 20o. EXTERNAL CAUSE WAS PRIMAR OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of Item 18.) CAUSE OF DEATH Fell at Home 20c TIME OF INJURY Month Dov Year 20e PLACE OF NJURY (Home form, (City or town) (County) (Stote) foctory, street, office bldg, etc) Not While of work While 5 may be retained for your O FUNERAL DIRECTOR: Page of work 1967 Home Paw Paw Hamps. W.Va. Inspection X, Inquiry X. 21. I certify that I taak charge of the remains described above, held an Autopsy 77, and in my apinian Natural causes Accident Suicide Hamicide Undetermined manner the funeral director. death resulted fram-CHIEF MEDICAL EXAMINER 22. DATE SIGNEO ASS STANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER March 12. 1967 **EXAMINER'S** NAME (Type) Benedict Skitarelic, M.D. Address (Street, cty, town, or countiumberland. Md. 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION. (County) Mt. Union Cem. Slanesville, W. Va. 250 REC'D BY REGISTRAR Homes, Berkeley Spgs VR A15ME (5) 6M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #3 Film OF DEATH CERTIFICATE death. requires that the death certificate be executed within 24 hours after death puo 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) by the attending physicion ond completely filled in by the funeral ransit permit. Then, please, remove corbon papers Pages I ond PLACE OF DEATH b. COUNTY o. COUNTY o. STATE ALLEGANY hoursafter MARYLAND MARYL AND ALLEGANY ELENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) DAYS CUMBERLAND CUMBERLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS event, within 72 50 WAVERLY TERRACE 451 MEMORIA YES NO SC NAME OF 4. DATE Month Year Last DOY DECEASED OF MARCH 67 GEORGE BROWN 19 (Type or print) DEATH 9. AGE (In years IF UNDER 24 HRS S. SEX 6 COLOR OR RACE 7 MARRIED DATE OF BIRTH IF UNDER 1 YEAR NEVER MARRIED last birthdoy) Months Dovs Hours MALE WHITE WIDOWED ond in any DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life even if retired) COUNTRY? WEST Individual VIRGINIA Plummer Helper 13 FATHER S NAME 14. MOTHER'S MAIDEN NAME crematian, or removo ROBERT BROWN WHITE. ABBIE 15. WAS DECEASED EVER IN .. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 217-10-7230 HOSPITAL CUMBERLAND. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the buriof-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) physicion. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (o). DUE TO for use as the t f Health prior to b stoting the underlying couse Page 4 may be retained by the hospital ar ottending **O FUNERAL DIRECTOR:** After this certificate has been lost. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES 🗀 NO 20o, ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) be detoched for Stote Dept. of H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Yeor 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While at work at work 21. I certify that (1) (this haspital) attended the deceased from the man 20, 19 2 - 210 director, page 3 should should be filed with the saw the deceased alive an Man. 221967, and that death accurred at ___M, fram causes and an the date stated above. 220 SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS 22d ADDRESS 22c. PHYSICIAN'S CUMBERLAND. MD. NAME (Type) CLAY 230. BURIAL, CREMATION, BENOVAL (Specify) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF (County) (Stote) Mar.25.1967 Davis Memorial Cem. Cumberland . Md . Allegany Scarpelli, Cumberland, Md. 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 MAR 28 1967



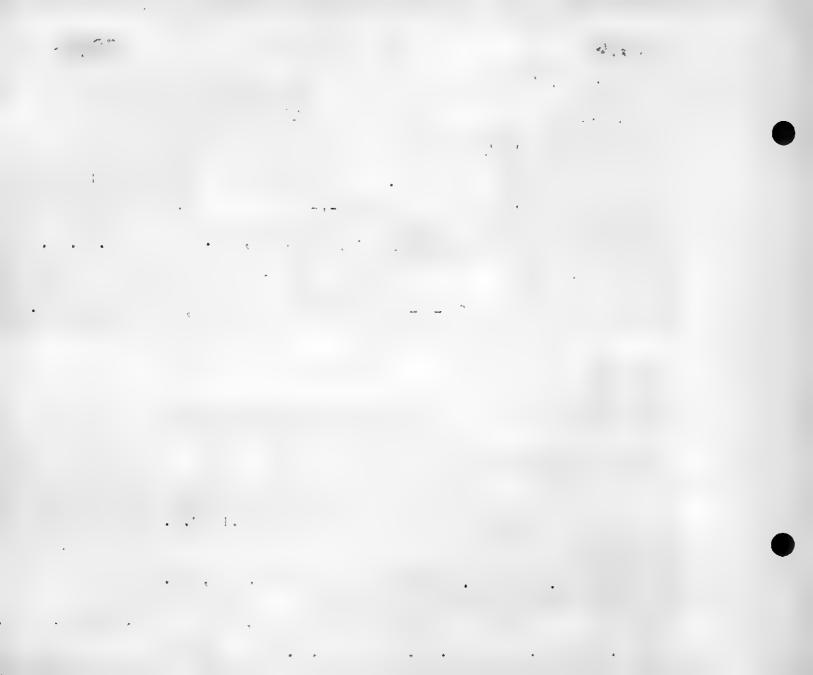
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02942 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND o. COUNTY **6 COUNTY** the attending physician and campletely filled in by the fun-sit permit. Then please remave carban papers. Pages 1 of nation, or remaval, and in any event, within 72 haurs after d ALLEGANY GARRETT MARYEAND b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) FROSTBURG (RURAL) FROSTBURG 2 DAYS d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS MINERS HOSPITAL NO F 3. NAME OF First Middle 4. DATE Lost Month Dov Year DECEASED LAWRENCE **JOHN** CAREY MARCH 27, 67 19 (Type or print) DEATH IF UNDER 24 HRS SEX 6 COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH AGE (In years **IF UNDER 1 YEAR NEVER MARRIED** birthdoy) Hours MALE WHITE AUG. 10, 1884 WIDOWED DIVORCED 12 CITIZEN OF WHAT 10a USUAL OCCJPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working the even if refired)
RETIRED FARMER COUNTRY? MARYLAND 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME JAMES CAREY ADA BLOCHER 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) MRS. ROY KNEPP, 69 PINE ST., FROSTBURG, MD. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c). burial-transit QNSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) signed by DUE TO Conditions, if only, which gove rise to immediate cause (a). DUE TO stoting the underlying couse as the this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO DI far 20o. ACCIDENT WAS UNDERLYING ... 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Hour o.m Not While ot work O FUNERAL DIRECTOR: After ot work 19 (2) to many 27 19 6 7 that (1) (we) last 2). I certify that (I) (this hospital) attended the deceased from ______ Page 4 may be retained saw the deceased alive an march 2719 67, and that death occurred at M. from causes and on the date stated above. 22b. DAJE SIGNED 22n. SIGNATURE ATTENDING STAFF PHYS DIRECTOR 22d ADDRESS 22c PHYSICIAN S JOHN B. DAVIS. M. D. NAME (Type) 2 BROADWAY, FROSTBURG, MD. director, shauld be 230 BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BURRHADYAL (Specify) MAR. 30 167 BLOCHER CEMETERY COUNTY. GARRETT 24. FUNERAL DIRECTOR ADDRESS 2So RECID BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) APR 3 Villagelen Judge 1967 JOSEPH R. DURST, SR., FROSTBURG, MD.





230 BALTO AVE. CUMBERLAND MD DAMAR

20 M 1/66





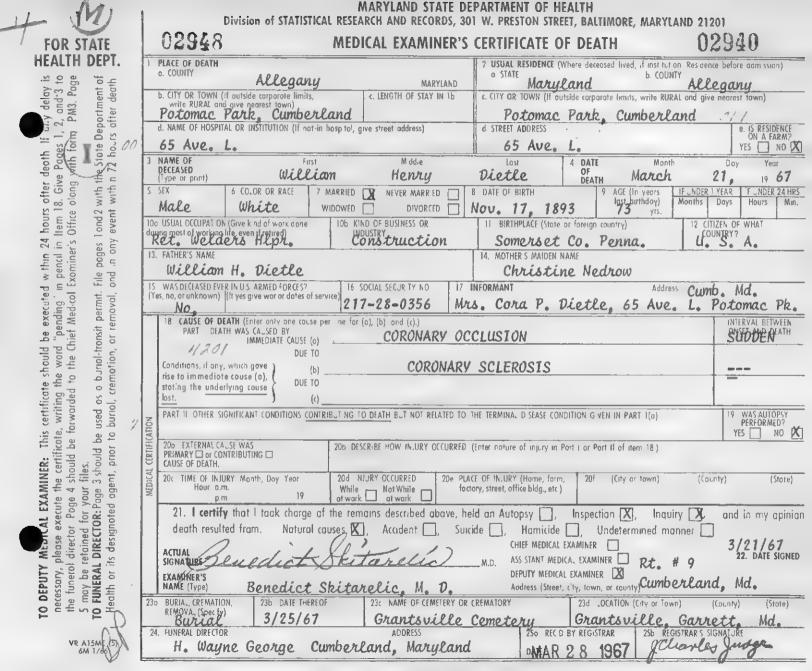
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02946 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEP 2 USUAL RESIDENCE (Where deceased lived, if institution Residente before domission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY and 3 to M3. Page Allegany

b CITY OR TOWN (if outside corporate fimils, Maryland Allegany after death. MARYLAND c. LENGTH OF STAY IN 1b. c CITY OR TOWN (If outside comparate limits, write RURA), and give nearest town). write Pland ord over town Maryland Cumberland d. NAME OF HOSPITAL OR INSTITUTION (it not in hospito), give street address) e. IS RESIDENCE d STREET ADDRESS hours ON A FARM? 317 Pulaski Street in stem 18. Give Pages YES NO TO Near Oldtown, Maryland 3 NAME OF 4 DATE DECEASED Leo (Type or print Francis Costello DEATH March 1967 6 COLOR OR RACE 9 AGE (n years IF UNDER 1 YEAR S SEX 7 MARRIED THE B DATE OF BIRTH F .. NDFR 24 HRS NEVER MARRIED 43 vrs Male White Feb. 1. 1924 WIDOWED DIVORCED IDo JSUAL OCCUPATION (Give kind of work done during most of working life even if retired) 11 BIRTHPLACE (State or foreign country) 1Db KIND OF BUSINESS OR 12 CITIZEN OF WHAT MasoHary Contractor COUNTRY? Knoxville, Tenn. USA 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Michael J. Costello Elizabeth Smith Costello Roberts 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (figes give wor or dotes of service) 16 SOCIAL SECURITY NO 17 INFORMANT Brother removol. Mr. C. J. Costello, Cumberland, Md. INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter on y one couse per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. Suddan DEATH Multiple Injuries 0 IMMEDIATE CAUSE (o). used os o burial-tr buriol, cremotion, DHE TO (Plane Crash) Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse PART II. OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAK DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? YES NO 2Do EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port I of item 18.) PRIMARY Or CONTRIBUTING Pilot of Plane which crashed CAUSE OF DEATH. 20e. PLACE OF INJURY (Hame farm, 20f (City or town) 2Dc. TIME OF INJURY Month, Doy Year 2Dd INJURY OCCURRED Oldtown, Allegany, Md. near 21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspect an X], Inquiry [X], and in my opinion Notural causes . Accident . Suicide . deoth resulted from Homicide Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE . DEPUTY MEDICAL EXAMINER K March 2, 1967 EXAMINER'S BENEDICT SKITARELIC. M.D. Address (Street, city, town, or county) Cumberland. M.D. 5 moy | O FUNE NAME (Type) 23d LOCAT ON (City or Town) 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL, CREMATION 23b DATE THEREOF (County) Burlal (Specify) March 4. St. Mary's Cemetery Cumberland, Md, Allegany 250. REC D BY REGISTRAR Scarpelli, Cumberland, Md. VR A15ME IS 6M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02947 he low requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before own ssion) PLACE OF DEATH MARYI AND **b** COUNTY ALLEGANY o. COUNTY ALLEGANY MARYLAND c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 b. CITY OR TOWN (If autside corporate I mits, completely filled in by the LA VALE. MD. 4 DAYS d. STREET ADDRESS IS RESIDENCE ON A FARM? and in ony event, within 72 ha d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 540 BRADDOCK AVENUE AL HOUPITAL Midd e 4. DATE 3. NAME OF First MARCH 67 DECEASED DAVIS SUE KIMBERLY DEATH (Type or print) IF UNDER 24 HRS 9. AGF (In years IF UNDER 1 YEAR DATE OF BIRTH S SEX 6 COLOR OR RACE NEVER MARRIED 7 MARRIED last birthday) Haurs WHITE FEB. 28. FEMALE WIDOWED DIVORCED 12 CT ZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) 10b KIND OF BUSINESS OR 10o. USJAL OCCUPATION (Give kind of work done during most of working life, even it retired) INDUSTRY U.S.A. CUMBERLAND. MD. none 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME be detoched for use os the burial-tronsit permit. (Rens State Dept. of Heolth prior to burial, cremation, or removal JO ANN L. PRATT LARRY F. DAVIS Address 17. INFORMANT 16. SOCIAL SECURITY NO. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor ar dates of service) CUMBERLAND, MD. MEMORIAL HOSPITAL none INTERVAL BETWEEN ne for (a), (b), and (c) 1B. CAUSE OF DEATH (Enter only one cause per PART | DEATH WAS CAUSED BY signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physicion Deuts DIRECTOR: After this certificate has been signed by 5/2 mc - 23 week Sostution DUE TO Conditions, if any, which gave rise ta immediate couse (a), DUE TO stating the underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? WFDICAL CERTIF CATION NO 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 200. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) (Stote) 20e. PLACE OF INJURY (Home, farm, (City or town) 20d INJURY OCCURRED 20c TIME OF INJURY Month, Doy, Year factory, street, affice bldg, etc.) Nat While ot work at wark 21. I certify that (1) (this haspital) attended the deceased from 2:28 sow the deceased alive on 3-5 1966, and that death acc 1966, and that death occurred at: 15A M, from couses and on the date stated above. sow the deceosed alive on_ 22b DATE SIGNED 22a SIGNATURE STAFF PHYS. ATTENDING MED. DIRECTOR M.D. PHYS 22c. PHYSICIAN'S GREENE ST .. CUMBERLAND. MD. DR. H. W. ELIASON NAME (Type) director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF 230 BURIAL, CREMATION, REMOVAL (Specify)
Burial March 6, 1967 Sunset Memorial Cumberland Park 2Sa. REC'D BY REGISTRAR REGISTRAPS 24. FUNERAL DIRECTOR Scarpelli, Cumberland, Md. DATE 20 M 1/66







Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH **FOR STATE** I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before edmission e. COUNTY **b.** COUNTY ALLEGANY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate lim.ts, write RURAL and give nearest town) write RURAL end give neerest town? ŏ FROSTBURG ${f FROSTBURG}$ d. NAME OF HOSP, TAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? retained the State B 22 McCULLOH STREET 22 McCULLOH STREET nay be retained with the State its affer death. YES NO K 3. NAME OF Middle 4. DATE DECEASED T.TT.L.TAN (Type or print) MAE DOERR DEATH MARCH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX E. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS. may 1 lest birthday) Months Hours FEMALE WIDOWED I AUG. 17, 1889 DIVORCED 10a, USUAL OCCUPATION (Give kind of work 106, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stelle or foreign country) 1 12. CITIZEN OF WHAT COUNTRY? done during most of working life, aven if retired) Pages HOUSE WORK OWN HOME NEW YORK U.S.A. 13. FATHER'S NAME PM3. 14. MOTHER'S MAIDEN NAME JOHN JOHNSON WILHELMINA WRIGHT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unknwn) ! (If yes alve war or dates of service) along with ARTHUR C. DOERR, FROSTBURG, MD. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Chronic Myocarditis. Pulmonary Edema IMMEDIATE CAUSE (a) Days **DUE TO** Arteriosclerotic Cardiovascular disease Conditions, if eny, which gave rise to Immediata cause DUE TO (e), stelling the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTORSY PERFORMED? Adenocarcinoma of Recto-sigmoid Medical NO should 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of Item 18.) 206. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 1 20f. (City or lown) (State) factory, street, office bidg., etc.) Not While While at work | et work be forwarded to the RAL DIRECTOR: 21. I certify that I took charge of the remains described above, held an Autopsy | Inspection y Inquiry v and 'n my opinion death resulted from: Natural causes X Suicide Undetermined manner CHIEF MEDICAL EXAMINER designated ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE should be for FUNERAL DEPUTY MEDICAL EXAMINER [March 26. 1967 BENEDICT SKITARELIC. M.D. Address (Street, city, town, or councumberland, Maryland 22a, BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, town, or country) REMOVAL (Spacify) Z40 TARRYTOWN, N. Y. BURIAL 29 167 23. FUNERAL DIRECTOR REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE ADDRESS VS. A15ME JOSEPH R. DURST, SR., FROSTBURG, MD. 5M 9/60



~/h	Á	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND						
7	-		02950 CERTIFICATE OF DEATH 02	942				
	hours after death. d in by the funeral rs. Pages 1 and 2. hours after death.	1.	PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, 11 institution: F a. STATE PENNSYLVANIA b. COUNTY BE					
	1 24 hours after filled in by the papers. Pages hin 72 hours after		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. CITY OR TOWN (if outside corporate limits, write RURAL RD#1 Hyndman, P.	and give nearest town)				
	24 filler paper in 72		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Membeial Hospital	e. IS RESIDENCE ON A FARM? YES NO M				
		l	TOTAL LANDER TO THE PROPERTY OF THE PROPERTY O	Day Year				
		1	Female White WIDOWED DIVORCED Dec. 25, 1891 75 Months	Days Hours Min.				
			a. USUAL OCCUPATION (Give kind of work done ring most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 12. C C C C C C C C C C C C C C C C C C C	USA USA				
	certifica ding ph Then remova		Samuel F. Wilson Maria Smith					
	death (e atten permit, ion, or	(Y	es, no, or unkown) (If yes give war or dates of service) 211-40-1222T Mr. Russell Emerick, Hyndman, PA					
	at the sian. ed by th transit i cremat		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage	INTERVAL BETWEEN ONSET AND DEATH 3 hrs				
	O HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician director, page 3 should be detached for use as the burial-transit permit. Then please should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in the state Dept.		Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized arteriosclerosis DUE TO (c)					
	The law all or atte ficate ha or use a Health pu	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	PERFORMED? YES NO				
	PHYSICIAN: the hospital this certifi detached for e Dept. of H		2Da. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury In Part I or Part II of Item 18 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (Court of Injury In Part I or Part II of Item 18 OF INJURY (Home, Injury In Part II or Part II of Item 18 OF INJURY III OF ITEM 18 OF ITEM	inty) (State)				
	NG PH by the lifter th be det State D	MEDICAL	Hour a.m. While Not While factory, street, office bldg., etc.) p.m. 19 at work at work	inty) (State)				
	TO HOSPITAL OR ATTENDING PHYSICIAN Page 4 may be retained by the hospit TO FUNERAL DIRECTOR: After this certificactor, page 3 should be detached should be filed with the State Dept. of		saw the deceased alive on 3.13.67 19 , and that death occurred at 9:20% from the causes and on t	that (I) (we) last he date stated above. ATE SIGNED 3.14.67				
	Page 4 may O FUNERAL D director, pag should be file		22c. PHYSICIAN'S NAME (Type) William P. Iames, M.D. 22d. ADDRÉSS 441 N. Centre St, Cumberlar					
	Page Page TO FU direc	238	Burial (Specify) March 15, 1967 Pabl Alto Cemetery Hyndman, Pa. RD#1					
	VR AI5 (4) (29	ADDRESS 253. REC'D BY REGISTRAR 256.	Judge				



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ely filled in by the funeral ban papers Pages 1 and 2 within 72 haurs after-death. requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY a. STATE b. COUNTY. ALLEGANY MARYLAND MARYLANDALLEGANY CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERT AND LIFE CUMBERLAND d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM? DOA MEMORIAL HOSPITAL 628 LINCOLN STREET YES NO completely fi nave carban 3 NAME OF First Middle 4. DATE Last Manth Doy Yeor DECEASED (Type or print) 0F FERGUSON MABEL MARCH 21 19 67 DEATH antendent, IF UNDER 1 YEAR IF UNDER 24 HRS. 5 SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years remave 7. MARRIED **NEVER MARRIED** lost birthdoy) Months Haurs WHITE FEMALE MIDOWED DIVORCED JULY 9. 1901 and 100 USJAL OCCUPATION (Give kind of work done during most of working fe, even if refired) 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician nen please ease INDUSTRY COUNTRY? and HOUSEWIFE OWN HOME BERLIN. PA. USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remaya DANIEL SWARNER AGNES IRVIN 15 WAS DECEASED EVER IN U.S. ARMED FORCE S? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, np. or unknown) (If yes give wor or dotes af service) NONE CUMBERLAND. ANDREW FERGUSON MD. crematian, 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the priartal has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION State Dept. of Health NO TO FUNERAL DIRECTOR: After this certificate YES 24 P 20a. ACCIDENT WAS UNDERLYING [205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) 20c. TIME OF INJURY Manth, Day, Year (County) (State) foctory, street, affice bldg, etc.) Nat While of work at work to Muich, 1967 that (1) we last 21. I certify that (1) (this haspital) attended the deceased fram. 24/6/19 6 Page 4 may be retained and that death accurred at 8010 M, from causes and on the date stated above. saw the deceased alive an_ 220. SIGNAJURE 22b. DATE SIGNED STAFF PHYS. 3.27.67 director, page 3 shavid be filed v DIRECTOR M.D 122c. PHYSICIAN'S ADDRÉSS VIRGINIA AVE. CUMBERLAND, MD. M.D. NAME (Type) 23b DATE THEREOF 23g. BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stole) BURLAL (Specify) MARCH 28,1967 ROSE HILL CEMETERY 25a. REC'D BY REGISTRAR 25 ADDRESS 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 BYRON KIGHT CUMBERLAND, MD.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please reports sarban papers. Pages 1 and 2 burial, cremation, ar removal, and in any event, within 72 haurs after death PLACE OF DEATH requires that the death certificate be executed within 24 hours after deat USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o COUNTY ALLEGANY MARY! AND b. COUNTY ALLEGANY MARYLAND b CITY OR TOWN (If autside corporate limits. CLENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOX 126A. DAY CUMBERLAND. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e IS RESIDENCE ON A FARM? d. STREET ADDRESS YES NO IX Memorial Hospital NAME OF Middle 4. DATE OF Lost Year DECEASED BABLE MARCH 19 67 BRENDA LEE 20 Type or print DEATH event 9 AGE (In years S SEX 6 COLOR OR RACE IF UNDER ! YEAR IF UNDER 24 HRS. DATE OF BIRTH 7 MARRIED NEVER MARRIED lost wirthday) Doys Months Hours FEMALE WHITE 3 25-66 WIDOWED DIVORCED 20 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote or foreign country) 100 USUAL OCCUPATION (Give kind of work done 12, CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? U.S.A. CUMBERLAND. MD. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME JUDY YRKESISHAM SEARS JOHN GABLE 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service MEMORIAL HOSPITAL CUMBERLAND. MD. 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove MYOCARDIAL rise to immediate cause (a), DUE TO stoting the underlying couse attending has been DISORDER lost SD P WAS AUTOPSY PERFORMED? YES NO PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Page 4 may be retained by the haspital ar this certificate jo 20o. ACCIDENT WAS UNDERLYING 20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) 20c TIME OF INJURY Month, Doy, Yeor (County) (Stote) factory, street, office bldg., etc.) Hour o.m. ot work O FUNERAL DIRECTOR: After at work 21. 1 certify that (1) (this haspital) attended the deceased from , 19___, that (I) (we) last to_______, 19_____, that (I) (we) last 20P M, from causes and an the date stated above. 19 and that death accurred at saw the deceased alive on, 220 SIGNATURE 22b. DATE SIGNED **ATTENDING** MED DIRECTOR 22c. PHYSICIAN'S 22d ADDRESS 500 GREEN ST., CUMBERLAND, MD. NAME (Type) director, should b 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (Stote) Burial (Specify) 3/23/67 Cumberland Allegany Maryland Sunset Memorial Park 24 FUNERAL DIRECTOR **ADDRESS** MAREC 2 B REGISTOT CESTER S SIGNATURE VR A15 (4) 20 M 1/66 H. Lee Silcox Cumberland Maryland 21502



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02953 **CERTIFICATE OF DEATH** Reg. Dist. No. 02945 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed v a. COUNTY Maryland Allegany **b.** COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporale limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) LaVale LaVale d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? 102 Weigand Drove 102 Weigand Drive YES | NO | .≘ NAME OF Middle 4. DATE 1967 Jane. Galkord March (Type or print) DEATH Sana 6. COLOR OR RACE 7 MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months DIVORCED [7] WIDOWED TX Female 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Cass. W. Va. Own Home U.S.A. Housewike 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Cassell Louise (Cassell) Cassell 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT 102 Weigand Drive. LaVale. Mc Mrs. Mary Bittner No. None 18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (0) Uremia **DUE TO** Carcinoma of Cermix 2 years Conditions, if ony, which] gove rise to immediate **DUE TO** couse (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPST PERFORMED? Diabetes Mellitus, Generalized arteriosclerosis YES I NO P 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, affice bldg., etc.) (County) (State) Hour a. m. Not while ol work of work Nov 3.6.67 21. I certify that I attended the deceased from ___, 19____,that I last saw the deceased alive on 2.27.67 _____, and that death occurred at 12:15PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) **DATE SIGNED** ACTUAL 3/9/67 441 N. Centre St. PHYSICIAN'S William P. Iames. M.D. Cumb. M d. NAME (Type) 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) REMOVAL (Specify) Hillcrest Burial Park Cumberland, Allegany, 23. FUNERAL DIRECTOR'S SIGNATURE 24g REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE Michaelen H. Wanne George Cumberland. 15M 10/57



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1	1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201								
: [:]		02954	CERTIFICATE	OF DEATH	029	946				
The low requires that the death certificate be executed within 24 haurs after death ottending physician. Has been signed by the attending physicion and completely filled in by the funeral se as the buriol-transit permit. Then please remove carbon popers. Pages I and the prior to buriol, cremation, or removal, and in any event, within 22 hours ofter death.	1.	PLACE OF DEATH O. COUNTY ALLEGANY	MARYLAND	2 USUAL RESIDENCE (Where deceased a STATEMARYLAND	1 COLLEGE	e before admission) _EGANY				
ertificate be executed within 24 haurs after physicion and completely filled in by the form piecse remove carbop popers. Pages noval, and in any event, within 22 hours often		b CITY OR TOWN (f autside corporate limits, write RURAL and give nearest tawn) CUMBERLAND	20 DAYS	CUMBERLAND		01-1				
in 24 ho illed in popers.	L	d. NAME OF HOSPITAL OR INSTITUTION (If not in MEMORIAL HOSPI	TAL	26 N. MECHANI	c st.	IS RESIDENCE ON A FARM? YES				
ed within		NAME OF First DECEASED (Type or point) ANN.		GAUGHAN OF DEATH	Manth MARCH	14 19 67				
execute nd comp emove any eve		FEMALE WHITE W	WIDOWED X DIVORCED	11-5-95	AGE (In years IF JNDER i last puthday) Months yrs	Doys Hours Min.				
ate be icion ar nease r and in	dur	JSJAL OCCUPATION (Give kind of work dane ing most of working life, even if retired) HOUS LWIFE FATHERS NAME	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPEACE (County & State or fore) ELK GARDEN, W 14. MOTHER'S MAIDEN NAME	" COL	IZEN OF WHAT UNTRY? U.S.A				
certific ng phys Then p		GEORGE WARNER WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17 II	SUSAN KENN	Address					
te deoth ce attending permit. The	(Ye	es, no, or unknown) (If yes give wor or dotes of sen	215-20-6424 N	MEMORIAL HOSPIT		AND, MD.				
that the death certifian. by the attending phy tronsit permit. Then cremation, ar removal		, , , , , , , , , , , , , , , , , , , ,	Congestive Haar	t Failure		ONSEL AND DEATH				
O HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the Page 4 may be retained by the hospital or ottending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be defacted for use as the burial-tronsit should be filed with the State Dept. of Health prior to burial, cremat		Conditions, if ony, which gave (b) (b) DUE TO	Arterioscleroti	c cardiovascula	r disease	yearw				
The low re or ottending e has been use as the alth prior to		stating the underlying cause (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTR	DIRITING TO DEATH RIT NOT PHATED TO T	HE TERMINAL DISEASE CONDITION GIVEN	IN PART 1(a)	VZQOTILA ZAW 91				
dal or oth	MEDICAL CERTIFICATION	20₀ ACCIDENT WAS UNDERLYING □	20b. DESCRIBE HOW INJURY OCCURRED. (19. WAS AUTOPSY PERFORMED? YES NO				
S PHYSICIA the hospita this certific detached for e Dept. of I		OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year			City or town) (Cou	inty) (Stote)				
ATTENDING PHYSICIAN: etoined by the hospital or CTOR: After this certificate should be detached for unith the State Dept. of Hea		Haur a.m. p.m. 19	White Not While factor	ory, street, office bldg., etc.)	March III 19					
ATTENC Proined CTOR: A should vith the		21. I certify that (I) (this hospito sow the deceosed olive on Mar	ch 14 19 67 and that		22b. DA	ne date stated above				
TAL OR ATT may be retoi RAL DIRECTO Page 3 sha be filed with		22c PHYSICIAN'S	on Commy WD	22d. ADDRESS	11110	3-14-67 MD.				
TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be defached for use as the should be filed with the State Dept. of Health prior to		NAME (Type) DR. WYAND BURIAL, CREMATION, 23b. DATE THEREOF			TION (City or Town) ((County) (State)				
VR A15 (4)	24	REMOVAL (Specify) BUT 1a 1 FUNERAL DIRECTOR OF 19	ADDRESS	259 REC'D BY REGISTRAR	2Sb REGISTRAR'S SIG	Alleg Md.				
20 M 1/66	_	John J. Hafer, Jr.,	230 Ballto Ave. Cum	oertandpail v k 1918	7 Scharles	July -				



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02955 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY 0 hours after death. Allegany Maruland Allegany MARYLAND b (TY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 t C.TY OR TOWN (If outside torparate limits, write RURAL and give nearest town) write RURAL and give negrest town)
Cumberland Rawlings DOA d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e (S RES DENCE ON A FARM? Memorial Hospital Along U. S. Rt. YES NO X 3. NAME OF First Middle Month # 12 Z DECEASED Betsu Ross Gordon March DEATH 19 67 SEX 6. COLOR OR RACE 7 MARRIED B DATE OF BIRTH AGE (n veors F UNDER 1 YEAR JE UNDER 24 HRS NEVER MARRIED last birthday) Months Days White. Female WIDOWED Sept. 6. 1924 DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CT ZEN OF WHAT duing most of working life eyen firetired) NDUSTRY U. S. pages l Zihlman Aircraft Factory ≘ Former machine opr. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within Thomas R. Morgan Nannie B. Scott Fire 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT Address (Yes, no, ar unknown) (If yes give war or dates of service used as a burial-transit permit, burial, cremation, or remaval, Mr. Quinton Gordon, Rawlings, Maryland IB CAUSE OF DEATH (Enter only one couse per ne for (a), (b) and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY Sudden Gunshot of Head IMMED ATE CAUSE (a) This certificate should the word DUE TO (Self-inflicted) Conditions if any, which gave rise to immediate cause (a), DUE TO storing the underlying couse PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19 WAS AUTOPS PERFORMED? 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of invery in Port I or Part I of Item 18) 3 should PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20d INJURY OCCURRED 20c TME OF INJURY Month, Day, Year Hour aim 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) factory street, office bldg, etc.) may be retained for your FUNERAL DIRECTOR: Page at wark 21. I certify that I took charge of the remains described above, held an Autopsy XI. Inspection XI. Inquiry X. and in my opinion death resulted from: Natural couses . Accident . Suicide X Homicide Undetermined manner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE × O DEPUTY DEPUTY MEDICAL EXAMINER & March 26, 1967 **EXAMINER'S** Benedict Skitarelic, M.D. Address (Street, city, town, or councumberland. Md. NAME (Type) 230 BUR AL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 50 nr. Rawlings, Allegany 3/29/67 Biertown Cemetery Md. 24. FUNERAL DIRECTOR 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15ME (S) H. Wayne George Cumberland, Maryland



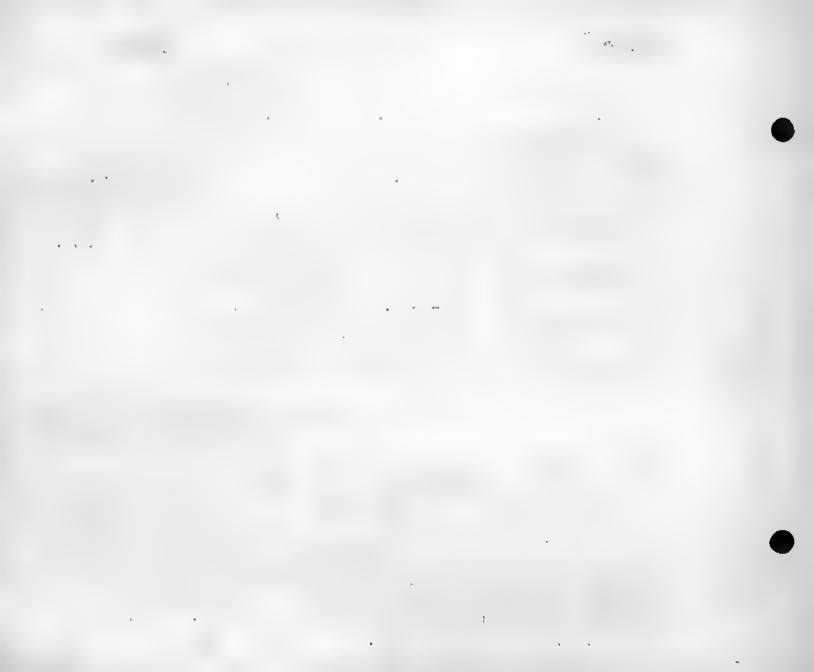
VR ALSME (5) 1/65

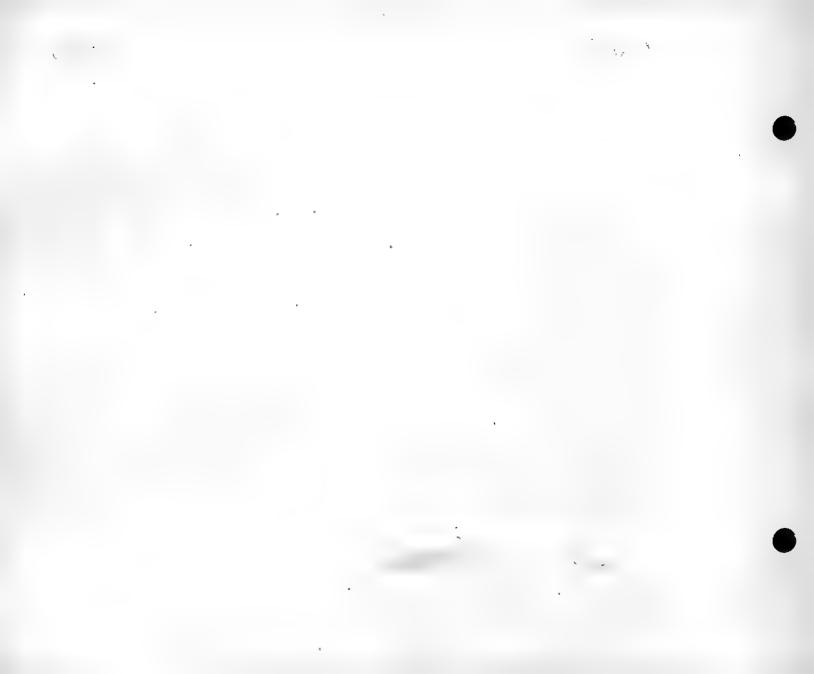
- 1: 7 and he 4.701

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02957 requires that the death certificate be executed within 24 haurs after death ond deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY ALLEGANY MARYLAND ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RIPAL and give negrest town) 4 DAYS FROSTBURG filled in by d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? RT. 2, BOX 356 MINERS HOSPITAL YES 🗀 NO T witiw NAME OF Middle 4. DATE Last Month Dov Year physician and campletely en please remaye garban DECEASED OF DEATH EDITH B. HAINES MARCH Type or print 19 67 ₽ # S SEX 6 COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS 8. DATE OF BIRTH 9. AGE (In years 7 MARRIED NEVER MARRIED last p rihday) Manths Days Haurs PEMALE WHITE SEPT. 20, 1895 WIDOWED DIVORCED 10g, US_AL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CIT ZEN OF WHAT COUNTRY? during most of working life, even if retired) HOME WEST VIRGINIA 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME remayal, the attending phys ROBERT NELSON ETTA HAINES IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT 늄 214-07-6091B T. LEE HAINES, FROSTBURG, MD. crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c),) INTERVAL BETWEEN burial-transet PART I DEATH WAS CAUSED BY ONSET AND DEATH Carcinomatosis, primary in upper G.I. IMMEDIATE CAUSE (a) __ DUE TO tract. Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying cause the the has been last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO Page 4 may be retained by the hospital are O FUNERAL DIRECTOR: After this certificate YES ţ 20g ACCIDENT WAS UNDERLYING [1] 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Doy, Year Hour a.m factory, street, affice bldg, etc.) Not While at work at wark 2). I certify that (I) (this haspital) attended the deceased fram 10/22/66, 19 ta 10/5/67, 19___, that (I) (we) last 10/5/67 saw the deceased alive an and that death accurred at_ M, fram causes and an the date stated above. 22g SIGNATURE 22b. DATE SIGNED MED. DIRECTOR ATTENDING STAFF PHYS. 3/6/67 M.D. 22d. ADDRESS 22c PHYSICIAN'S ALVIN J. WALTERS, M. D. NAME (Type) AS BROADWAY, FROSTBURG, MD. director, shauldl 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23d LOCATION (City or Town) (Caunty) (State) BURIAL (Specify) MAR. 8 167 DAVIS MEMORIAL CEMETERY OLDTOWN RD 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** 25a. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 JOSEPH R. DURST, SR., FROSTBURG, MD.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02958 CERTIFICATE OF DEATH deoth. l ond PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE a. COUNTY b. COUNTY ALLEGANY ATTEGANY popers Poges I hin 72 hours after MARYLAND requires that the death certificate be executed within 24 haurs after completely filled in by the fi b CITY OR TOWN (If outside corporate rimits, CLENGTH OF STAY IN 15 c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) 3 WKS. MT. SAVAGE d. NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? MINERS HOSPITAL YES NO X 3 NAME OF Middle 4. DATE First Last Month Day Year DECEASED JOHN E. HARDEN MARCH 19 67 30. DEATH I IF UNDER 24 HRS. S SEX 6 COLOR OR RACE AGE (In years IF UNDER T YEAR 7. MARRIED **NEVER MARRIED** 8. DATE OF BIRTH Jost birthdoy) Months Dovs Hours MATE WHITE DIVORCED WIDOWED MARCH 25. 1902 1Da. USJAL OCCUPATION (G-ve kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) RESTAURANT INDUSTRY MARYLAND 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME EDWARD HARDEN ANNIE THORP 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT (Yes, na, ar unknown) (If yes give wor ar dates of service) 213-10-9111 MRS. MARGARET W. HARDEN, MT. SAVAGE, MD. cremotion. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) buriol-tronsit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DITE TO Canditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying cause as the O FUNERAL DIRECTOR: After this certificate has been lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY PERFORMED? for use NO D 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I ar Part 11 of item 18.) 2Da ACCIDENT WAS JNDERLYING □ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dc. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 2De PLACE OF INJURY (Harne, form, (City or town) (County) (Stote) Hour a.m. Not While factory, street, office bldg., etc.) at work Page 4 moy be retained by 21. I certify that (1) (this hospital) attended the deceosed from march 10, 1967, to march 30, 1962, that (1) (we) last saw the deceased alive an march 30 1907, and that death occurred at 12 32 MM, from couses and an the date stated above. 22a, SIGNATURE **ATTENDING** PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S JOHN B. DAVIS, M. D. 2 BROADWAY, FROSTBURG. MD. NAME (Type) director, should 23d. LOCATION (City or Tawn) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, (County) (State) BURTAL (Specify) MT. SAVAGE, MD. METHODIST CEMTERY 256 REGISTRAR'S SIGNATURE 25a. REC D BY REGISTRAR DURST, SR., FROSTBURG, MD. VR A15 (4) 20 M 1/66



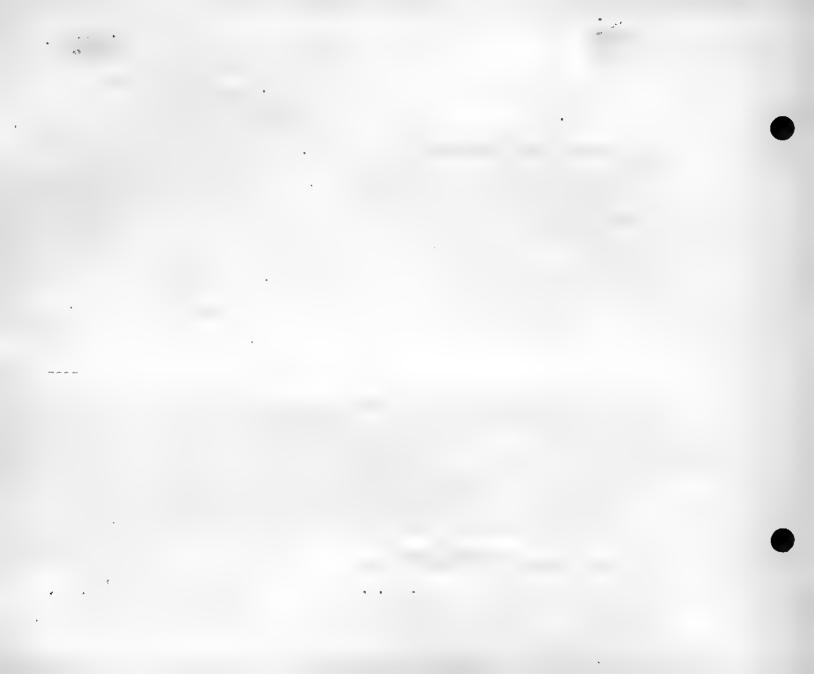


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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0296; MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATES HEALTH DEPT PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY 3 to Page b COUNTY 4 Allegany Allegany MARYLAND delay b CITY OR TOWN (If outside carparate I mits. c SENGIR OF STAY IN 16 c EITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) 2, ond PM3 F write RURAL and give negrest tawn) Cumberland DOA Flintstone a NAME OF HOSPITAL OR INSTITUT ON (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? hours ote Sacred Heart Hospital Box 96 YES NO TXI 3 NAME OF 4 DATE Reffee Month DECEASED 1967 (Type or print) Dorothy 不进步进产 Johns DEATH S SEX 9 AGE (In years IF UNDER 1 YEAR JE UNDER 24 HRS 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED NEVER MARR ED last birthdov) Months WIDOWED DIVORCED 2/22/6/1 Office, event female 10a USJAL OCCUPATION (Give kind of work done LOB KIND OF BUSINESS OR 11 B RTHPLACE (State or fore an country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Maryland IIS A 14. MOTHER'S MA DEN NAME 13 FATHER'S NAME be executed within Burton Johns Anna Ruth Reed Harold 15. WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address Md. (Yes, na, or unknown) (If yes give war ar dates of service) removal. None Harold B. Johns. Route 1. Box 96. Flintstone 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Acute Pulmonary Congestion and Edema ö MATERIAL SIMMEDIATE CAUSE (0) This certificate should DIJE TO Conditions, if any, which gave Patent Interventricular Septum cremot rise ta immediate cause (a). DUE TO stating the underlying cause burial, (Congenital) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(g) 9 WAS AUTOPS PERFORMED? NO 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (State) foctory, street, office bldg., etc.) 21 I certify that I taok charge of the remains described above, held on Autopsy to. Inspection , inquiry 😴 and in my opinion Natural causes Accident Undetermined manner death resulted fram-Suicide | Homicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER March 8, 1967 **EXAMINER'S** FUNER Health BENEDICT SKITARELIC. M.D. Address (Street, city, town, or county) Cumberland. Md. NAME (Type) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, 23d LOCATION (City or Town) (County) (State) W. Va. Mar. 10, 1967 Buckhannon Uoshur Buckhannon Memorial Park 25b. REGISTRARS SIGNATURE OCCUPANTES JUNGER 25g, REC D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5) Md MAR 9 1967 fer. 230 Balto Ave. Cumberland. 6M 1/66



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, It institution e. COUNTY b. COUNTY Maryland Allegany Allegany MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give nearest town) Cumberland, Maryland Cumberland. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM Allegany County Infirmary 606 Greene St. YES NO P 3. NAME OF 4. DATE Month Year DECEASED (Type or print) Eleanor Johnston DEATH March 1957 Humbird catbon 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH IF UNDER 24 HRS. and NEVER MARRIED 9. AGE (In years . IF UNDER 1 YEAR last birthday) Months Hours certificate 1890 Nov. 17 .. White Female WIDOWED. DIVORCED IX physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Cumberland, Maryland U.S.A. Ret. Saleslady Jewelry Store 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Bertie Hitchcook Albert Charles 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address 21207 (Yes, no, or unkown) | (Ifyesgive werordetes of service) Mr. William E. Johnston 3409 Ripple Rd. Balto, 18. CAUSE OF DEATH [Enter only one cause per INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if env. which (b) geve rise to immediate ceuse DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT WAS AUTOPSY CERTIFICATION PERFORMED? prior NO IV 20e. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of Item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dev. Yeer 20d. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, ferm,) 20f. (City or town) (Stete factory, street, office bldg., etc.) While Not While Hour a.m. et work et work p.m. M, from the causes and on the date stated above saw the deceased alive on. and that death occurred at. 22a. SIGNATURE HOSPITAL FUNERAL DIRECTOR PHYS. M.D. ADDRESS 22c. PHYSICIAN'S NAME (Type) ector, filed 23a. BURIAL, CREMATION 1 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, lown or county) (State) 0 # 2 REMOVAL (Specify) Rose Hill Cemetery Cumberland, Alleganu 24 FUNERAL DIRECTOR'S SIGNATURE H. Waune George Cumberland, Maryland VR A15 (4) 20M 5-63

MARYLAND STATE DEPARTM

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02964 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) campletely filled in by the funeral nave carban papers. Pages 1, and the event, within 72 hours after-ded 1 PLACE OF DEATH o COUNTY o STATE **b.** COUNTY ALLEGANY MARYLAND ALLEGANY MARYLAND b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give mearest town) CUMBERLAND DAYS CUMBERLAND e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS WASHINGTON-LEE APTS MEMORIAL HOSPITAL requires that the death certificate be executed within 3 NAME OF First 4 DATE Middle Lost Month Year DECEASED MARCH **ESTHER** KI AWAN , 1967. PLATT (Type or print) DÉATH S SEX B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR F UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** birthdoy) Months Doys Hours 2-25-1882 FEMALE WHITE ond in any WIDOWED DIVORCED 12 CITIZEN OF WHAT 10o USUA, OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR [1] BIRTHPLACE (County & State, or foreign country) U.S.A. during most of working life, even if retired)
HOUSEWIFE INDUSTRY LITHUANIA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, ar remayal, FRIEDBERG PLATT WAS DECEASED EVER IN ILS ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) MEMORIAL HOSPITAL-CUMBERLAND. MD. 220-44-5687 INTERVAL BETWEEN ONSET AND DEATH IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the REMIA IMMEDIATE CAUSE (6) DUE TO ENDOMETRIAL CARCINOMA Conditions, if ony, which gove rise to immediate cause (o), DUE TO stating the underlying couse EXTENSION as the prior to b Page 4 may be retained by the haspital or attending has been last. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? far use NO YES this certificate 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER 20e, PLACE OF INJURY (Home, form, (City or town) 20d. INJURY OCCURRED 20f. (County) (Stote) 20c. TIME OF INJURY Month, Doy, Yeor factory, street, office bldg .etc.) Not While ot work FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram_ 1967, and that death occurred at M. from causes and on the date stated above. sow the deceased olive on_ 22o. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR ATTENDING STAFF PHYS. M D PHYS director, page should be filed 22d. ADDRESS 22c. PINICIAN'S NAME (Type) SAMUEL M. **JACOBSON** 50 PERSHING ST.. CUMBERLAND MD. 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION 23b. DATE THEREOF 23d LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) Md 3/27/67 East View Cemetery Cumberland. Alleg 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR **ADDRESS** 25b. REGISTRAR'S SIGNATURE VR A15 (4 230 Balto Ave. Cumberland Milyllo 20 M 1/66 Hafer



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02965 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) 1 PLACE OF DEATH a COUNTY **b.** COUNTY MARYL AND **ALLEGANY** MARYLAND the attending physician and campletely filled in by the f sit permit. Then please remove carban papers. Pages nation, ar removal, and in any éve<u>at, w</u>ithin 72 haurs afte b CITY OR TOWN (I outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) 2DAYS BARTON d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MEMORIAL HOSPITAL d STREET ADDRESS e IS RESIDENCE ON A FARM? YES 🔲 NO NAME OF Middle First Last 4. DATE Month DECEASED (Type or print) OF MARCH CHARLES KYLE DEATH 9. AGE (In years last bestleday) 8 DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** 9-26-1900 WHITE WIDOWED DIVORCED 31 BIRTHPLACE (County & State or fareign country) 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY MOSCOW. MARYLAND RETIRED 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, ar remaval, FRANK KYLE ANNIE LEE 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. Address O FUNERAL DIRECTOR: After this certificate has been signed by the attendidancers, page 3 shauld be detached far use as the burial-transit permit. (Yes_na_ar unknawn) (If yes g ve war ar dates af service) 217#05-0987 MEMORIAL HOSPITAL. CUMBERLAND, MD. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: ENSET AND BEATH Lobar Pneumonia left lower IMMEDIATE CAUSE (a). Page 4 may be retained by the hospital ar attending physician. DUE TO 470 X Conditions, if ony, which gove Dehydration. Metabolic Acidosis ? rise to immediate cause (a), DUE TO far use as the b f Health priar ta b stating the underlying couse last. 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 3 should be detached far use with the State Dept. of Health Psychesiswith depression, Coronary Arteriosclerosis, Myocardial Fib YES [20a ACCIDENT WAS UNDERLYING □ 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (County) (State) 20c TIME OF INJURY Manth, Day, Year factory, street, office bldg., etc.) Ngt While at work at work 21. I certify that (I) (this haspital) attended the deceased from Mar. 9, 19.67 to Mar. 11, 19.67, that (I) (we) last saw the deceased alive an Mar. 10, 19.67, and that death accurred at 7:20 kg, from causes and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING MED DIRECTOR STAFF PHYS. Mar. 14, 1967 co long director, page 3 shauld be filed v M.D. 22d. ADDRESS 224: PHYSICIAN'S NAME (Type) JACOBSON. 50 PERSHING ST., CUMBERLAND, MD. 23c NAME OF CEMETERY OR CREMATORY Rost Lawn 23b. DATE THEREOF 23d LOCATION (City or Town) 23o. BURIAL, CREMATION (County) (Stote) BEMOVAL (Specify) LaVale 3/14/67 Md. **ADDRESS** 24 FUNERAL DIRECTOR Westernport. Md.



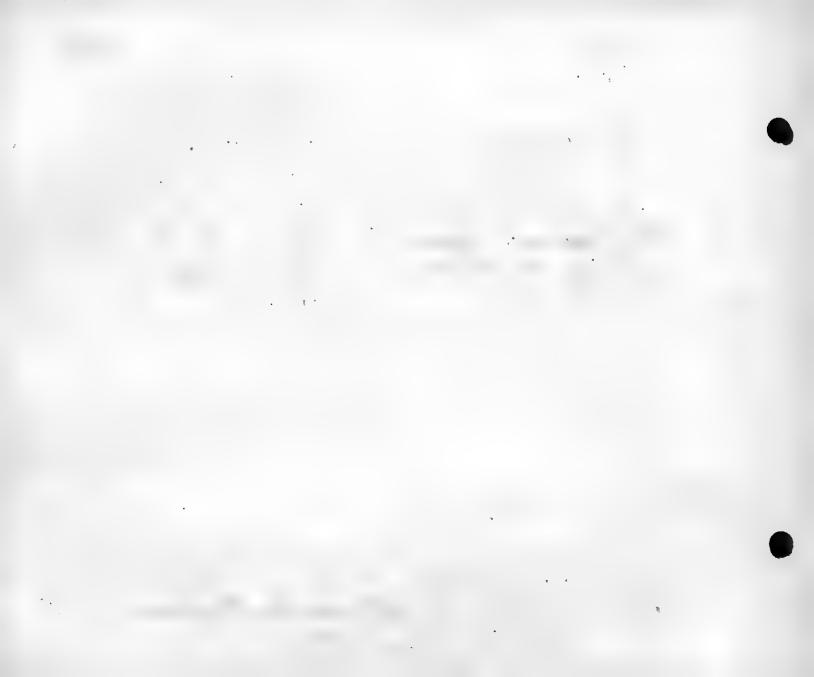
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH taineral and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTY d in torthe to rs. Pages I 2 hours after (b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Allegany Marvland MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 24 hours Cumberland Cumber land 24 yrs. Md. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) filled d. STREET ADDRESS 6. IS RESIDENCE ON A FARM? ding physician and completely filled Then please remove carbon papers removal, and in any event, within 72 Sacred Heart Hospital 117 Frederick Street NO TO executed within 3. NAME OF Middle Last DATE Month Day DECEASED (Type or print) DEATH Paul 1567 Vincent Leasure March 5. SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HR\$ 8. DATE OF BIRTH 9. 7. MARRIED Y NEVER MARRIED last birthday) Months Days WIDOWED [DIVORCED Male 1942 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? Funeral Director
13. FATHER'S NAME Funeral U.S.A. Home Allegany certificate MOTHER'S MAIDEN NAME TO FUNERAL DIRECTOR: After this certificate has been signed by the attending director, page 3 should be detached for use as the burial-transit permit. They should be filed with the State Dept. of Health prior to burial, cremation, or remov Vincent. Paul Leasure
15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unkown) (If yes give war or dates of service) Josephine Schute 16. SOCIAL SECURITY NO. Address death Vincent P. Leasure 117 Frederick St. Sr. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). PHYSICIAN: The law requires that the hospital or attending physician. Adenocarcinoma of the intestine mo. DUE TO Conditions, If any, which 14 mo (b) Abdominal carcinomatosis gave rise to immediate DUE TO cause (a), stating the underlying cause last, (c) Intestinal obstruction

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) underlying cause last, WAS AUTOPSY CERTIFICATION PERFORMED? YES I NO 72 20a. ACCIDENT WAS UNDERLYING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) none MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Hour a,m. While Not While be retained by at work at work p.m. 21. I certify that (I) (this hospital) attended the deceased from April 8, 1966, to March 15, 1967, that (I) (we) last saw the deceased alive-office 15, 1967, and that death occurred at AM, from the causes and on the date stated above. SIGNATURE 22b. DATE SIGNED 3-16-67 TO HOSPITAL C Page 4 may 1 M.D. DIRECTOR PHYSICIAN'S ADDRE NAME (Type) 140 Bedford St., Cumberland, Nd. James BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) Buriel & Paul Cemetery Cumberland FUNERAL DIRECTOR DATE VR A15 (4) 15M 4-64

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}	by the funeral Pages 1 and 2 urs after death.	1.	PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE	CE (Where deceased	lived, If institution b. COUNTY	: Residence before admissi	on)
	ffer ffer			LLEGANY	MARYLAND	MA	RYLAND		ALLEGANY	
	by 1 Page Urs a			(if outside corporate limits, and give nearest town)	c. LENGTH OF STAY IN 1b			limits, write RUI	RAL and give nearest tov	Vn)
	24 hours filled in by apers. Pa n 72 hours		d. NAME OF HOSP	TAL OR INSTITUTION (If not in i	hospital, give street address)	d. STREET AODRESS	AND		e. IS RESIDEN	ICE
			SACRED H			MORNING S	IDE DRIVE		ON A FARM	
	completely we carbon p event, withi	3.	NAME OF DECFASED	First	Middle	Last	4. OATE OF	Month	Oay Year	
	comple we carl event,	5.	(Type or print)	VINCENT 6. COLOR OR RACE 7 MARRIET	JOSEPH	LINDNER B. DATE OF BIRTH	DEATH	3/7/67	19 FR 1 YEAR HF UNDER 24 H	IRS.
	executed within 1 and completely remove carbon n any event, withi		MALE	WHITE WIOOWED		9/9/1893	last 7	birthday) Month		
	ian a	10a	. USUAL OCCUPATION	DN (Give kind of work done 10b. i	KIND OF BUSINESS OR	11. BIRTHPLACE (C	ounty & State, or fore		CITIZEN OF WHAT	_
	ite be iysicia please i, and	4		yearman /ele	phone (0	allegar	1	ty	COUNTRY?	
	ath certificate be attending physician rmit. Then please in, or removal, and in	13.	PATHER'S NAME	R	· luca	14. MOTHER'S MAIL	DEN NAME IR	1. 12.		
	h cer tendir nit. T or rer	15	WAS DECEASED EY	FER INU.S. ARMED FORCES? 16 If yes give war or dates of service)	. SOCIAL SECURITY NO. 17.	INFORMANT	CC IVIII	Address		—
	death c he atten permit, tion, or I	(11	y 10, or oncoming to	WWI		PT'S CHAR	T			
	uires that the deal g physician. en signed by the al buria-transit perr burial, cremation,			EATH [Enter only one cause per TH WAS CAUSEO BY:	line for (a), (b), and (c) 1		(_	INTERVAL BETWEE	H
	hat t cian. ed b ed b tran , cre		1631	IMMEDIATE CAUSE (a)	5.24.2000	t. The whole	21 1	120-21	10 MI	71
	es t ohysi sign urial urial		Conditions, If ar	OUE TO (b)						
	ding pring property of the prince of the pri		gave rise to in cause (a), state	mmediate (
	aw re ttendii has be as th prior	×	underlying cause	last.) (c) GNIFICANT CONDITIONS CONTRIB	UTING TO DEATH BUT NOT BELL	TEOTOTHE TERMINAL	NICE ACE CONDITION	VOIVEN IN DART 1	(a) 119. WAS AUTOP:	Ŷ?
	is The law requires that the death certificate be all or attending physician. Instant has been signed by the attending physician ficate has been signed by the attending physician for use as the burial-transit permit. Then please Health prior to burial, cremation, or removal, and in	CERTIFICATION	FARE (I. OTHER SI	SITTE CAME COMPITTORS CONTRIB	OTTING TO DEATH BOT NOT RELA	TEO TO THE TERMINAL	OISENSE CONDITION	A GIA CH IIA LAVA T	PERFORMED YES NO	?
	AN: T pital of rtifica of for of Hea	RTIFI	20a. ACCIDENT W	VAS UNDERLYING [] 20b.	DESCRIBE HOW INJURY OCCU	RREO. (Enter nature o	f Injury In Part I o	r Part II of Item		_
	PHYSICIAN: the hospital this certifi detached fo e Dept. of H			G CAUSE OF DEATH FY MEDICAL EXAMINER)						
	The part of the pa	MEDICAL	Hour a.m.	While	Not While facto	CE OF INJURY (Home, fa ry, street, office bidg., e	arm, 20f. (City o	r town) (County) (State)
	DING PI ed by th After t id be de e State	×	p.m.	that (I) (this hospital) attent		vire.€11	9 6 5 to 5	/ 7 19	€ / that (I) (we) I	ast
_	R ATTENDIN e retained RECTOR: Af 3 should with the S			eased alive on		death occurred at	15	, , , , , , , ,	n the date stated abo	
	REC'E		22a. SIGNATURE	1		ATTENDING	MED \$1	AFF 22b.	DATE SIGNED	
	rat or nay be at. DIR page filed		22c. PHYSICIAN		M.D	22d. AOORESS	DIRECTOR P	iys.	3/1/6/	
	osenia e 4 r e 4 r in ER ild be		NAME (Typ	e) DRS. GLICK & SI	PIGGLE					
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that in Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, cre-	2 3 a	REMOVAL (Spec		23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATIO	N (City, town or	county) (state)	
		24	FUNERAL DIREC	TOR	ADORESS ADORESS	25a, RE	c'o by REGISTRAR 8 1967	25b REGISTR	AR'S SIGNATURE	_
	VR AI5 (4)	2	James	Stein Inc.	Cumb. V.	MAR.	8 1967	Julian	les Judge	
	20M 1/65	-							<u> </u>	





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02970 CERTIFICATE OF DEATH requires that the death certificate he executed within 24 hours after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY ALLEGANY o. STATE **b.** COUNTY MARYLAND ALLEGANY MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

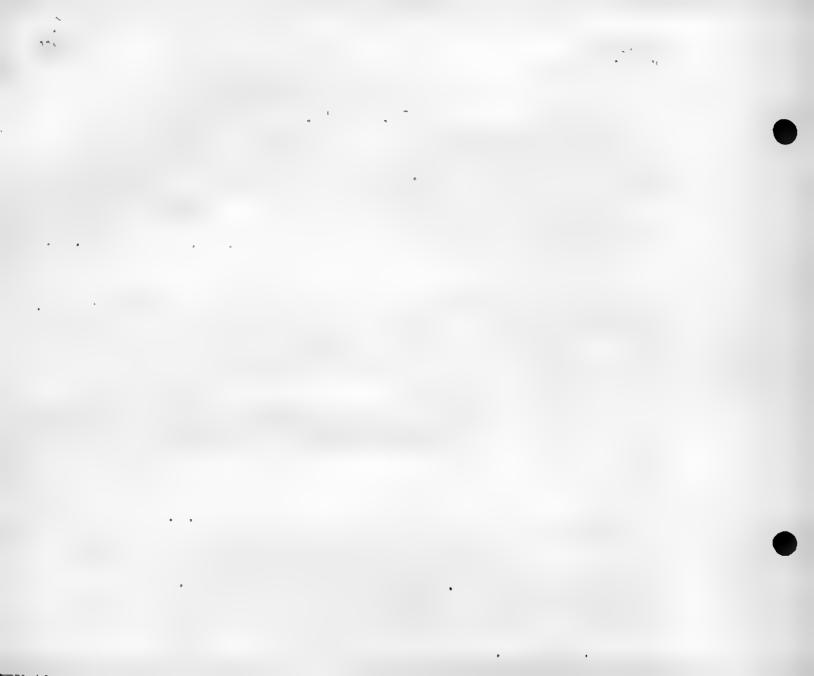
FROSTBURG c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) filled in by 4-5 YRS FROSTBURG d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS paper 49 BROADWAY 49 BROADWAY YES 🗔 NO 🔽 NAME OF First Middle 4. DATE Last Month Year the attending physician and completely sit permit. Then please remove carban DECEASED ISAAC T. LOVE MARCH 67 (Type or print) DEATH 19 SEX 6. COLOR OR RACE DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED remove birthday) Months Days Haurs MALE WHITE WIDOWED I DIVORCED NOV. 20. 1896 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT Curing most of working life, even if retired)
RETIRED MERCHANT COUNTRY? STORE MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ISAAC LOVE MARY - LAIRD IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, na, or upknown) (If yes give wor or dotes of service) 214-32-3072 MRS. STELLA BOETTNER, FROSTBURG, MD. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) signed ! DUE TO Conditions, if any, which gave Lotknew rise to immediate cause (a). DUE TO stoting the underlying couse Page 4 may be retained by the hospital or ottending D FUNERAL DIRECTOR: After this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES 🗌 NO [20g ACCIDENT WAS UNDERLYING IT 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20e PLACE OF INJURY (Hame, form, (City or town) (State) 20d INJURY OCCURRED (County) factory, street, office blda., etc.) Not While at work 21. I certify that (I) (this haspital) attended the deceased fram Jen 15 ___, 19<u>62</u>, that (I) (we) last , 19 6.7, to march 9 saw the deceased alive on Morch 5 1967, and that death accurred at M, fram causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. DIRECTOR PHYS. director, poge S 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) PAIGE STRONG, M'. D. 167 E. MAIN ST., FROSTBURG, MD. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23d LOCATION (City or Town) (County) (State) BURIAL (Specify) FROSTBURG, MD. 12 167 FB'G, MEMORIAL PARK 24. FUNERAL DIRECTOR VR A15 (4) JOSEPH R. DURST. SR., FROSTBURG, MD. 20 M 1/66



	12	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	E 504 /	The state of DEATH 02963
1 mile	fumer fumer	1. Mate of death a. COUNTY a. STATE OF UTRITUTE B. COUNTY B. COUNTY D. COU
	after the state of	MARYLAND MARYLAND
	24 hours appears. Page n. 72 hours	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town write RURAL and give nearest town) L. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PIRIMONI PIRIMONI
	hod leers.	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENT DN A FARMS
		SACRED HEART 40 PITAL 14 PORTS STREET YES NOTE
	completely ve carbon evert, with	3. NAME OF DECEASED (Type or print) THERESA A. LIPIS DEATH MAR. 11 19 67
	execute in and co	S. SEX 6. CDLOR OR RACE 7. MARRIED NEVER MARRIED S. DATE OF BIRTH 9. AGE (in years IFUNDER 1 YEAR IFUNDER 24 HI last bythday) Months Days Hours Mill FEMALE WITTE WIDOWED X DIVORCED Feb. 16, 1993 74 76 yrs. Toa. USUAL DCCUPATION (Give kind of workdom of working life, even if retired) 10b. KIND DF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT COUNTRY?
	te be ysician please , and il	Ttalv U.S.A.
	certifica Iding ph Then I	
	ndin rem	Nicola Argiro Angela Fanto 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
	e death cerl the attendin t permit. Tl atlon, or ren	(Yes, no, or unknown) (If yes pive war or dates of service) Patient's Emergency Room Chart
	the the ratio	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
	hat the death cian. ed by the atter-transit permit. cremation, or	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (8) Conceptive Heart failure School
	es t ohysi sign urial urial	Conditions, if any, which gave rise to immediate (b) Generaling of Anticipality 20 973
	aw requir ttending p has been as the b prior to b	cause (a), stating the DUE TO underlying cause last. (c)
	The law or atten ate has use as astalth price	
	_ 0 = 0	Q on □ say allelle M allelle Mo Q NO
	Pit	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) 19. WAS AUTOPS PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) 19. WAS AUTOPS PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.)
	G PHYSIC by the hos er this co e detache ate Dept.	20c. TIME OF INJURY Month, Day, Year 20d. INJURY DCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Hour a.m. p.m. 19 while Not While factory, street, office bidg., etc.)
	NDIN ned b t: Aff uld b the St	21. I certify that (I) (this hospital) attended the deceased from 6, 1966 to 3/11, 1967, that (I) (we) la
	etail etail Sho sho ith t	saw the deceased alive on 3/11 19 67, and that death occurred at 12 5M, from the causes and on the date stated above 22a, SIGNATURE
	AL OR A nay be r lay be r lay be r lay be r lay bage 3 page 3 filed w	M.D. ATTENDING MED. STAFF 3/12/67
	PITAL 4 ma ERAL or, pi	22c. PHYSICIAN'S NAME (Type) Wayne C. Spiggle 126 N. Smallwood St., Cumberland, Md
	Page Page Of FUN direct Shoutc	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME DF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	F = 2	Burial 3/14/67 St. Peters Cemetery Westernport, Alle Md. 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR 25b. REGISTRAR 25b. REGISTRAR 25b. REGISTRAR 25b. REGISTRAR 25b. REGISTRAR 25c. REGIST
	VR A15 (4)	(1) A from De Piedmont, W. Va. MAR 2 0 1967 yourses Judge
	20M 1/65	



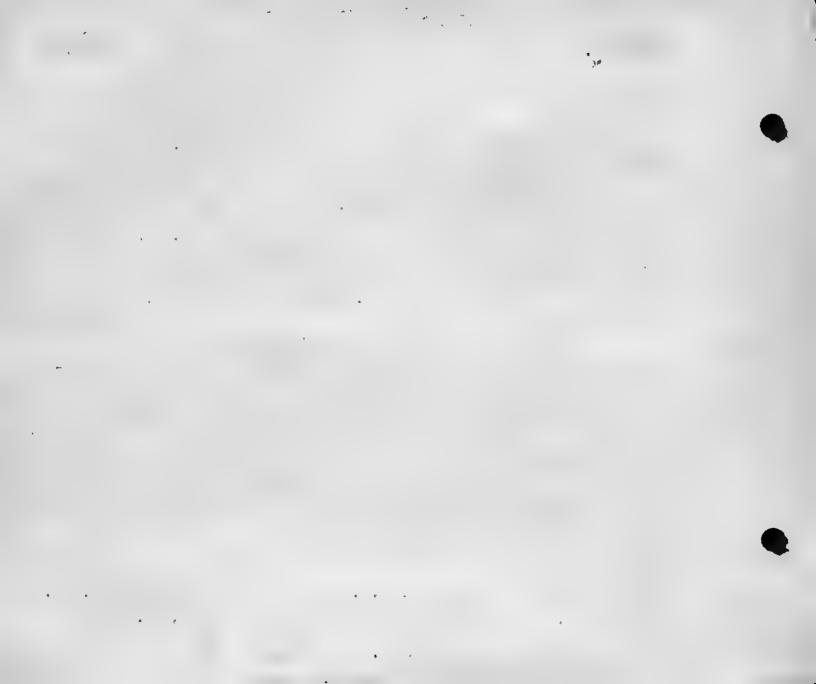
MARYIAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ond 2 death. filled in by the funeral papers. Pages 1 and 2 thin 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) requires that the death certificate be executed within 24 hours after deap I. PLACE OF DEATH ALLEGANY ALLEGAN o. COUNTY O. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, HRS. 50 MIN. STREET ADDRESS 5 NATIONAL HIGHWAY filled in d NAME OF HOSPITA, OR INSTITUTION (If not in hospital, give street oddress) MEMORIAL HOSPITAL IS RESIDENCE ON A FARM? YES TO NO T 3 NAME OF DECEASED completely find version 4. DATE MARCH MICHAEL LYNCH 67 (Type or print) DEATH AGE (In years last pirthday) IF UNDER IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH NEVER MARRIED MALE WHITE Months Dovs Hours 5-2-96 WIDOWED DIVORCED buriol, cremotion, ar removal, and in an 12. CITIZEN OF WHAT 10p USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 31 BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY C & P R R during most of working the even if retired)
Retired Brakeman MT. SAVAGE, MD. 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME LYNCH MARGARET FLOOD JOHN IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dates of service) 17. INFORMANT 16 SOCIAL SECURITY NO. Address MEMORIAL HOSPITAL. CUMBERLAND, MD. 712-14-1567 MW T 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN **buriol-transit** ONSET AND DEATH PART I. DEATH WAS CAUSED BY: signed by 1 IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO for use as the fifeblished for the fireblished stoting the underlying couse Page 4 may be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate has been lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO PA YES 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of July in Part I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED foctory, street, office bldg., etc.) Not While 19 at work 21. I certify that (I) (this haspital) attended the deceased fram 1950, 19-20 tap M 3-29, 1967, that (I) (we) last saw the deceased glive an 3-29 1962, and that death accurred at M, fram causes and on the date stated above. saw the deceased alive an 3.29 1962, and that death accurred at 22o. SIGNATURE 22b. DATE SIGNED MED DIRECTOR **ATTENDING** 1 M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S CUMBERLAND. MD. NAME (Type) DR. WILLIAM P. IAMES director, should b 230 BURIAL CREMATION, REMOVAL (Specify) Burial — 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) Cumberland Alleg Md Sts Peter & Paul's Cath Cem 250 REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE - ADDRESS 24. FUNERAL DIRECTOR VCharles 1967 Hafer, Jr. 1230 Balto Ave. Cumberland 3



TO DEPUTY MX. IL EXAMINER: This certificate should be executed within 24 hours after death. If any dependence please execute the infecte, writing the word "pending" in pendil in Item 18. Give Pages 1, 2, and 3 to the funer, Pedor, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO PUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours affected by. VS. A15ME 5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

-1	_ 02973 MEDICAL EXAMINER 3	CERTIFICATE OF DEATH	U2955					
	1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution	n. Residence before admission)					
4	a. COUNTY	e, STATE b, COUNTY	4 H D					
ı	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b		Allgany					
- 1	write RURAL and give neerest town)	c. CITY OR TOWN (If outside corporete I m.ts, write RURAL	and give nearest fown)					
-1	CumberlandDOA	Ia_Vale						
ą I	d. NAME OF HOSPITAL OR INSTITUTION (ill not in hospitel, give street address)	d. STREET ADDRESS	IS RESIDENCE ON A FARM?					
41	Memorial Hospital	017 11/2= 142 - 1	YES NO W					
ı	3. NAME OF First Middle	943 Weires Ave.	Day Year					
J	DECEASED (Type or print)	OF	20 . (2					
7	Mattle Winona	Mangus	26 19 67					
1	Y. Michael X Market Michael	DATE OF BRTH 9. AGE (In years IF UNDE	1					
	Female White widowed Divorced Fe	eb. 10, 1890 77 yrs. Months	Days Hours Min.					
1	10a. USUAL OCCUPATION (Give kind o. work 10b. KIND OF BUSINESS OR INDUSTRY	11. B RTHPLACE (State or loreign country 12.	CIT ZEN OF WHAT COUNTRY?					
ŀ	done during most of working i.e. avan if ratired) Housewife Own Home	Berkeley Springs, W. Va.	USA					
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
1	John Courtney	Lillian Lutman						
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURTY NO. 17 II		_					
-	(Var. no. or i nkown) i (ffynta ynwererdetenfenniae)							
		. Dorsey Mangus, La Vale, M	d. Husband					
1	18. CAUSE OF DEATH [Entar only one cause per line for (e), (b), and (c).]		ONSET AND DEATH					
1	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COPONARY	Occlusion _	Sudden					
1	42°/ DUE TO							
1		- Colomonia	A1. M					
-	geve rise to immediate cause	y Sclerosis	70700					
-	(a), steling the underlying DUE TO							
1	causa last. (c)							
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT	RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PA	ART 1(a) 19. WAS AUTOPSY PERFORMED?					
۱	TA CONTRACTOR OF THE CONTRACTO		YES NO XX					
1	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Peri I or Peri II of Item 18.)							
	☐ PRIMARY ☐ or CONTRIBUTING ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐							
20c. TIME OF NJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) Hour e.m. While Not While fectory, street, office bldg., etc.)								
								profess of the property of the
	21. I certify that I took charge of the remains described above, he d an Autopsy, Inspection, Inquiry and in my opinion							
	death resulted from. Natural causes Accident	de, Homicide, Undetermined manner						
		CHIEF MEDICAL EXAMINER						
	SIGNATURE DE MAN STATE A POLITABLE	ASSISTANT MEDICAL EXAMINER	DATE SIGNED					
	Branch Company	DEPUTY MEDICAL EXAMINERXIX March	26. 1967					
7	NAME (Type) Benedict Skitarelic, M.D							
	22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR	CREMATORY 22d. LOCATION (City, town, or coun	try) (State)					
ı	Burial Mar. 29, 1967 Hillcrest Bur	ial Dark Cumberland, Md.	Allegany					
	23, FUNERAL DIRECTOR ADDRESS	24e. REC'D BY REGISTRAR 24b. REGISTRAR'S	~ ~					
		W/1-1						
	James F. Scarpelli, Cumberland, Md.	MAR 2 8 1967 Julian	1 0					



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02974 requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY b. COUNTY o. STATE Allegany Marvland Allegany MARYLAND b CITY OR TOWN (if autside carparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Years Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 46 Marion Street YES NO FE 46 Marion Street Middle 4. DATE 3 NAME OF First Last Month Day Year DECEASED 19 67 Tda Martin DEATH March (Type ar print) Frances 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 8 DATE OF BIRTH 6 COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months Days Haurs by the attending physician and co tronsit permit. Then please remover cremation, or removol, and in any WIDOWED DIVORCED October 18.1868 98 YES White Female 100 JSUAL OCCUPAT ON (Give kind of work dame 10b KIND OF BUSINESS OR 11, BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT **COUNTRY?** during most of working life, even if retired) INDUSTRY Hartmansville W. Va. 14. MOTHER'S MAIDEN NAME At Home U.S.A Housekeeper 13. FATHER S NAME John H. Bisel Anna Wingert Address 46 Marion Street 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, na, ar unknawn) (If yes give war ar dates of service) Cumberland, Md Carmekita Mamajek None INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line to PART I DEATH WAS CAUSED BY signed by the burial-trons burial, crem IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse be detoched for use as the State Dept. of Health prior to PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO [O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (Crty or town) (Caunty) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Nat While at work 19 E / that (I) (we) last 21. I certify that (1) (this haspita) attended the deceased from director, page 3 should should be filed with the M, fram causes and an the date stoted obove and that death occurred at. saw the deceased alive on. 22a. SIGNATURE STAFF PHYS. ATTENDING DIRECTOR M D ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL SPECIA 3/8/67 St. Patrick's Cemetery Cumberland Allegany Maryland VAR 9 196 24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Marvland 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



1	MARYLAND STATE DEPARTMENT OF HEALTH	
R STATE	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY 12975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 129	FLAND
THE DEPT.		co before edmission)
	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence a. STATE Maryland b. COUNTY Allegan	
	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give r	
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give recent town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give recent town) corriganville c. CITY OR TOWN (if outside corporate limits, write RURAL and give recent town) corriganville	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) d. STREET ADDRESS	ON A FARM?
	3. NAME OF First Middle Last 4. DATE Month Day DECEASED	Year
	(Type or print) Annie (Corley) May DEATH March 8	19 67
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE III years JIF UNDER I YEAR	IF UNDER 24 HRS.
	Female White wildowed D Divorced October 2, 1884 82 yrs.	Hours Min.
		F WHAT COUNTRY
	13. FATHER'S NAME 14, MOTHER'S MAIDEN NAME 19	
	John Metzger Corley Maria Mowery	
-1	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address [Yes, 30, or unknown] (Ityosgivewer or detector service) 212 51 8187 Miss Ethel May Cumber and Md	
	LIZE A COLO, CONTROLLER OF THE	
	18. CAUSE OF DEATH [Enter only one esuse per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, COPONARY OCCUSION	ERVAL BETWEEN
	IMMEDIATE CAUSE (a)	7444011
	Conditions if any, which a Coronary sclerosis	
	gave rise to immediate cause	
	(a), stating the underlying DUE TO	
	cause lest. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)). 11	9. WAS AUTOPSY
	[2]	PEMCHANICA
	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part I or Part II of item 18.)	YES NO X
	PRIMARY OF CONTRIBUTING C	
		(Stata)
	20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, feetory, street, office bldg., etc.) (City or lown) (County)	
		in my opinion
	death resulted from: Natural causes A. Accident . Suicide . Homicide . Undetermined manner	, opinen
	CHIEF MEDICAL EXAMINER	
	ACTURE O ASSISTANT MEDICAL EXAMINED D	ATE SIGNED
	SIGNATURE M.D DEPUTY MEDICAL EXAMINER	
	NAME (Type) Benedict Skitarelic, M.D. RD#9 Cumberland Riv, Md. or county) MArch	8, 1967
	22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or county)	(State)
	The state of the s	
	ADDRESS 248, REC'D BY REGISTRAR; 24b, REGISTRAR'S SIGNATU	IRE
	Howey It Kelgher Hyndman, Pennsylvania MAR 1 3 1967 Jellanles Ju	age.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02976 FOR STATE HEALTH DEPY PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 2, and 3. Page after death a COUNTY b. COUNTY Allegany Maryland Allegany MARYLAND Department b. CIY OR TOWN (If outside corparate limits, t. C.TY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) c JENGTH OF STAY IN 16 write RURAL and give nearest town) Frostburg Cumberland ll Hours. d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital give street address) d STREET ADDRESS S RESIDENCE ON A FARM? hours 209 E. Main Street Memorial Hospital ate YES 🗔 NO 1c Item 18. Give Pages alang with NAME OF 4 DATE Firs1 Month 72 Dov Year DECEASED the with the RAYMOND (Type or poot) McGUIRE DEATH March 6. COLOR OR RACE 9 AGE (n years 7 MARRIED 8 DATE OF BIRTH NEVER MARRIED Saft birthdoy) Months Hours Dovs Aug. 4, 1915 Male White WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

TAXI DRIVER 11 BIRTHPLACE (* .te or foreign country) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT COUNTRY? Maryland

14. MOTHER'S MAIDEN NAME SELF-EMPLOYED Ξ HI ONY Examiner's pencil 13. FATHER'S NAME pup Patrick McGuire Agnes Arnold 15 WAS DECEASED EVER N U.S. ARMED FORCES?
(Yes, no, grunknawn) (It yes give war or dates at service) 16. SOCIAL SECURITY NO 17 INFORMANT Addre 209 E. Main St., rd "pending' m Chief Medica, E permit removal. Mrs. Ruth McGuire, Frostburg, Md. 216-09-3825 No INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY 12 Hours 5 Ruptured Aorta IMMEDIATE CAUSE (o) This certificate shauld e, writing the ward forwarded to the Cl cremation, DUE TO Conditions, if only, which gove Fractured Sternum (b) rise to immediate couse (o), DUE TO stoting the underlying couse ш used as burial, c (Auto Accident) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS PERFORMED? YES X No 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of niury in Part I or Part II of item 18) PRIMARY OF CONTRIBUTING Driver of Auto in Rear End Collision CAUSE OF DEATH 20d INJURY OCCURRED 7 20e PLACE OF NJURY (Home, form, 20f (City or town) 20c TIME OF INJURY Month, Doy, Year (County) (Stote) Rt. 40 East of Grantsville Alleg. Md. Not While may be retained for your FUNERAL DIRECTOR: Page Warch 26.67 of work of work to 21. I certify that I took charge of the remains described above, held an Autopsy XX. Inspection XX Inquiry XX ond in my opinion Natural causes Accident XX. death resulted fram: Suicide . Homicide . Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 5 may be reta
TO FUNERAL DII 22. DATE SIGNED ASSISTANT MED CA. EXAMINER SIGNATURE _ TO DEPUTY DEPUTY MEDICAL EXAMINER March 26, 1967 **EXAMINER'S** Benedict Skitarelic, M.D. Address (Street, city, town or county) Cumberland Md NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION. 23d LOCATION (City or Town) BUTTA (Specify) Mar. 29 167 St. Michael's Cemetery Frostburg, Md. 2Sb REGISTRAR'S 5 GNATURE 24. FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR Ocharles Judge. VR A15ME\(SE Joseph R. Durst, Sr., Frostburg, Md. 6M 1/66

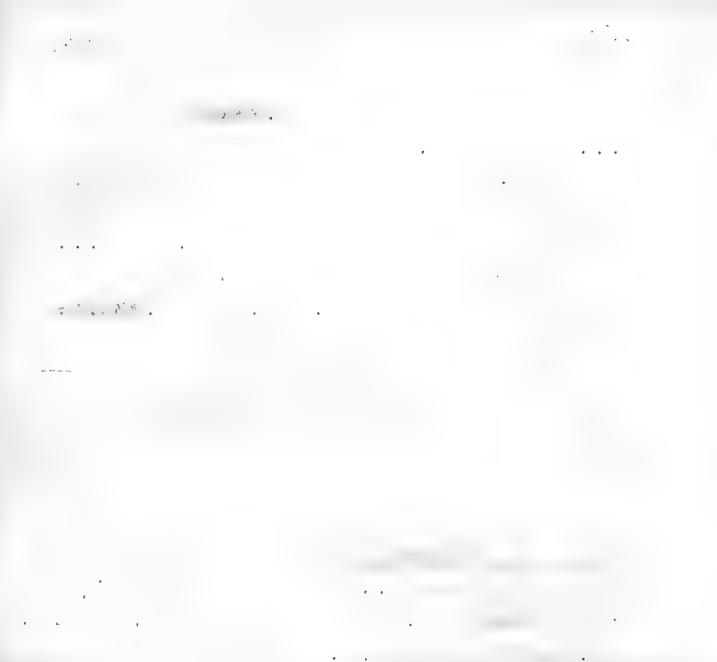


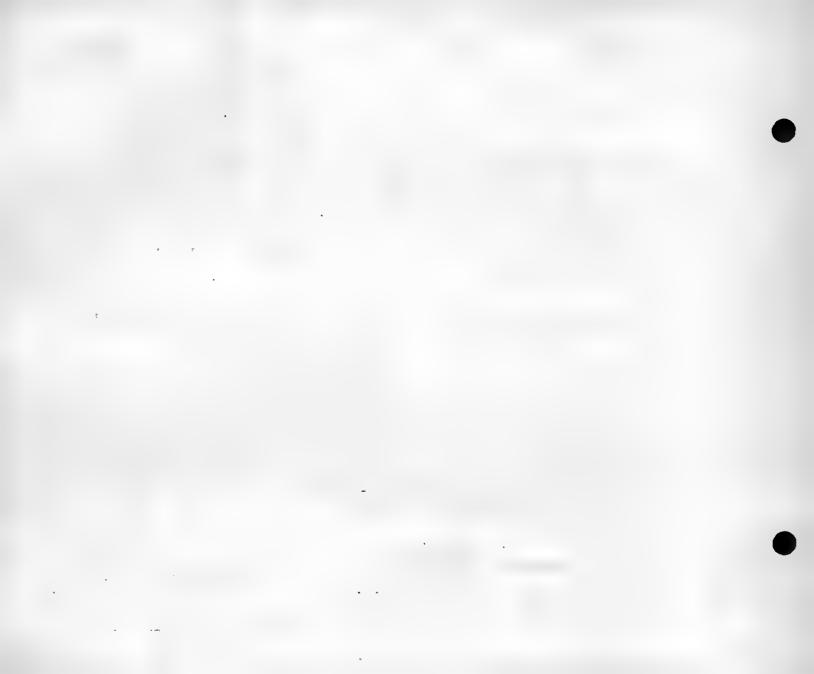
■0 M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02978 PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution o. COUNTY Allegany b COUNTY Poge Maruland Allegany jo ote Deportment of hours after death. MARYLAND b CIY OR TOWN (If autside carparate imits, c LENGTH OF STAY IN 1b c CITY OR TOWN (IF to me comparate limits, write RURAL and give negrest town? P.M.3. write RURAL and give negrest tawn) Cumberland Lunal! d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS with the State Dep S RESIDENCE ON A FARM? Sacred Heart Hosp. Fairgo Item 18 Give Poges Office along with for YES NO TX 24 hours after death 3 NAME OF Middle First Last 4 DATE Manth Day Year DECEASED OF DEATH Maria Holon McKenzie March 20 19 67 (Type or print S SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED ast b rthday) Months Days Haurs Female White 11/3/1900 WIDOWED DIVORCED ₽ eve 11 BIRTHPLACE (State or foreign country) 1Da USUAL OCCUPATION (Give kind of work done 106 K ND OF BUSINESS OR 12 CT ZEN OF WHAT Own Home during mast of warking life, even if retired)
Housewife Cumberland, Md. AUO Chief Medicol Exeminers penci 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME This certificate should be executed within = Paul Goldsworthy Anna M. Helferich pup WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, ar unknown) [(If yes give war ar dates af service burial, cremation, or removal, No. Mr. Paul W. McKenzie Rt. # 5 Cymberland. Md None 1B CAUSE OF DEATH (Enter only one cause per ne far (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. NTERVAL BETWEEN CHIEFTO HOLDEATH CORONARY OCCLUSION IMMEDIATE CAUSE (o) writing the word DUE TO Canditians, if any, which gave CORONARY SCLEROSIS rise to immediate couse (a), DUE TO stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? NO XX 5 may be retained to 7. To FUNIRAL DIRECTOR: Page 3 should be to Health or its designoted agent, prior to 2Do. EXTERNAL CAUSE WAS 20b DESCRIBE HOW NJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) PRIMARY OF CONTRIBUTING CAUSE OF DEATH 2Dc TIME OF INJURY Manth, Day Year 2Dd N. JRY OCCURRED 2De PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) Hour aim Not While factory, street office bldg. etc.) at wark 23. I certify that I taok charge of the remains described above, held an Autopsy Inquiry X Inspection X and in my opinion Notural causes XX / Accident deoth resulted fram: Suicide . Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY DEPUTY MEDICAL EXAMINER March 20. 2967 EXAMINER'S Benedict Skitarelic. M.D. NAME (Type) Address (Street, city, town, or county Crumborland Maruland 23b DATE THEREOF 23a BURIAL, CREMATION 23c NAME OF CEMETERY OR CREMATORY (Stote) SS. Peter & Paul Cemetery Cumberland. Allegany. 3/23/67 2Sa REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 256 REGISTRAR'S SIGNATURE VR A15ME (3) MAR 27 Cumberland, Md. Wayne George

MARYLAND STATE DEPARTMENT OF HEALTH





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02980 USUAL RESIDENCE (Where deceased lived, of institution Residence before admission) PLACE OF DEATH a. STATE b. COUNTY a. COUNTY ALLEGANY ALLEGANY event, within 72 hours after MARYLAND MARYLAND campletely filled in by the c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate imits, c LENGTH OF STAY IN 16 CUMBERLAND requires that the death certificate be executed within 24 haurs DAYS IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS HOSPITAL CUMBERLAND, MD. 215 HUMBIRD STREET I NO IX 3. NAME OF Middle 4 DATE Doy Year DECEASED HAROL D MARCH 19 67 DEATH (Type or print) IF UNDER 24 HRS. SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF JNDER 7 MARRIED NEVER MARRIED remave byrthdoy) Manths Hauts 27, WHITE FIJAN. MA! F WIDOWED DIVORCED and in any 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & Stote, or foreign country) 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR COUNTRY? during most of working life even if retired) INDUSTRY physicion MARYLAND B & 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, or removal, BESSIE VALENTINE JAMES W. MILLER IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) MEMORIAL HOSPITAL. CUMBERLAND. INTERVAL BETWEEN ONSEL AND DEATH CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) burial-transit PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO Cand tians, if any, which gove rise to immediate couse (a), DUE TO stating the underlying cause prior ta L Page 4 may be retained by the haspital ar attending far use as the lost. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) this certificate has director, page 3 should be detached far use should be filed with the State Dept. of Health NO 20a ACCIDENT WAS UNDERLYING □ 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Hame, farm, (County) (Stote) 20c TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED foctory, street, office bldg., etc.) Hour am. Not While ot work of work. O FUNERAL DIRECTOR: After 21 I certify that (I) (this hospital) attended the deceased from_ , and that death accurred at 8:35 M/Arom causes and an the date stated above saw the deceased alive an 3 22b. DAYE SIGNED 220. SIGNATURE ATTENDING M.D DIRECTOR PHYS. 22d. ADDRESS 22e PHYSICIAN'S ST. CUMBERLAND NAME (Type) 22 S. CENTRE RICHARD IAMS. M.D. 23d, LOCATION (City or Town) (County) BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) Alleg Md Near Cumberland Zion Memorial Park ./67 Buria 250 REC'D 8Y REGISTRAR **ADDRESS** 24. FUNERAL-DIRECTOR 1967 VR A15 (4) 20 M 1/66 Balto Ave. Cumberland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institutions a. COUNTY b. COUNTY Allegany Allegany Maryland MARYLAND b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If putside corporate limits, write RURAL and give nearest town) Cumberland Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Sacred Heart Hospital 5 Bellvue St. YES ND X within completely ve carbon p 3. NAME DE First Last DATE Year Middle Month Day DECEASED Myrl 19 67 Tva Mull DEATH 6 (Type or print) 6. COLOR OR RACE | 7. MARRIED 5. SEX 8. DATE OF BIRTH 9. NEVER MARRIED 2/12/99 Female white WIDOWED A DIVORCED [1Da. USUAL DCCUPATION (Give kind of work done | 10b, KIND DF BUSINESS DR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? USA Everett. Penna. Housewifé Own home death certificate removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME transit permit. Then p James T Emma Merkel Evans (Mearkle) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Buttery Price 16. SOCIAL SECURITYNO, | 17. INFORMANT (Yes, no. or unkown) | (If yes give war or dates of service) patient's chart Cumberland, Md 18. CAUSE DF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN DISSET AND DEATH PART I. DEATH WAS CAUSED BY: D.O. Carcinoma of the stomach IMMEDIATE CAUSE (a) burial-ti burial, i DUE TO Conditions, If any, which 4 ino Cachexia gave rise to immediate 書き **DUE TO** cause (a), stating the Underlying cause last.) (c) Prone.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) underlying cause last. as CERTIFICATION WAS AUTDPSY for use Health PERFORMED? certificate hospital or YES [ND F 208. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work D.M. 21. I certify that (1) (this hospital) attended the deceased from OV. 17., 19.66, to horch 6, 19.67, that (1) (we) last 19.67, and that death occurred at 12.40 Complete causes and on the date stated above. saw the deceased alive on larch 22b. DATE SIGNED 22a. SIGNATURE page DIRECTOR 3-6-67 M.D. ADDRESS FUNERAL director, p 22ć. PHYSICIAN'S 22d. NAME (Type) sediord St. 140 Jumber land. L.d. Hallinan James BURIAL, CREMATION, 23b. DATE THEREDF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. Bedford Co., Penna. 2 March 9. 1967 Madley Cemetery 25h REGISTBAR'S SIGNATURE **FUNERAL DIRECTOR** ADDRESS 25a. REC'D BY REGISTRAR I Everett. Pa. 1967 VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY b. COUNTY ALL EGANY MARYLAND ALL EGANY MARYLAND 24 haurs after b CITY OR TOWN (if autside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) CUMBERLAND DAYS CUMBERLAND e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS MEMORIAL HOSPITAL GRAND AVENUE YES 🔲 NO TX requires that the death certificate be executed within NAME OF First Middle Lost Month Year DECEASED NIXON MARCH 67 PAUL E. 19 (Type or print) DEATH 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX A COLOR OR RACE 7 MARRIED NEVER MARRIED tys Chirthday) Haurs 3-12-88 WHITE MALE WIDOWED X DIVORCED 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10g, USJAL OCCUPATION (Give kind of work done 17 BIRTHPLACE (County & State, or fareign country) COUNTRS? A during most of working life, even if ret red) INDUSTRY WEST VIRGINIA RETIRED HOSLER 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME E. MARTHA L. HARDY NIXON JAMES 1s. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO MEMORIAL HOSPITAL-CUMBERLAND, MD. (Yes, no, or unknown) (If yes give war ar dates of service) P War I wes crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY burial-transit p IMMEDIATE CAUSE (a) ò DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stoting the underlying couse as the After this certificate has been WAS AUTOPSY PERFORMED? PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use Health NO YES 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or tawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour o.m. at work 21. I certify that (1) (this hospital) attended the deceased from Mar. 3. 194 7, and that death occurred at 125 2m, from causes and an the date stated above FUNERAL DIRECTOR: saw the deceased alive on the 22b. DATE SIGNED 22a SIGNATURE DIRECTOR M.D PHYS. director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S 236 NAME (Type) CLAY VIRGINIA AVE..CUMBERLAND 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF 23a. BURIAL, CREMATION, March 9.1967 Rose Hill Mausoleum Cumberland, Md. Allegany 24. FUNERAL DIRECTOR Scarpelli, Cumberland, Md. VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. CDUNTY b. CDUNTY Al. legany Allegany Mary Land MARYLAND b. CITY DR TDWN (if outside corporate limits. C. LENGTH DE STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town) Mt. Savage. Cumberland week ben papers. within 72 h d. NAME DF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS DN A FARM? Socred Heart Hospital ND -YES completely ive carbon p death certificate be executed within NAME OF Middle DATE Last Month Day Year DECEASED remove carb O'Naal.Sr Clarence A. 1967 (Type or print) DEATH 5. SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR last birthday) Months | 8. DATE OF BIRTH IF UNDER 24 HRS 7. MARRIED WI NEVER MARRIED Hours and Male WIDDWED # DIVORGED [5 1Da. USUAL DCCUPATION (Give kind of work done) physician n please r 10b. KIND DF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT during most of working life, even if retired) INDUSTRY CDUNTRY? railroad matimad USA Penna. (COLEMONT 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova he attending permit. Then Hester Williams Hartman O'Neal 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT 0 (Yes, no, or unkown) ((If yes give war or dates of service) Il-transit perm 712-14-1576 patient's chart 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN DNSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction burial-t burial, 4501 DUE TD S Conditions, If any, which Arteriosclerotic heart disease gave rise to immediate the land DUE TD cause (a), stating the prior underlying cause last. Coronary sclerosis 10. as CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY 119. PERFORMED? certificate ND # YES the hospital 20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY DCCURRED. (Enter nature of Injury in Part I or Pert II of Item 18.) DR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) None MEDICAL 2Dc. TIME DF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 2De. PLACE DF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (State) (County) be de State Hour a.m. p.m. at work at work retained 21. I certify that (I) (this hospital) attended the deceased from April 8. toMarch 17., 19 67, that (I) (we) last 1966 saw, the deceased alive on March .19 67 and that death occurred ab 30 M from the causes and on the date stated above. DIRECTOR Ige 3 sho 22b. DATE SIGNED SIGNATURE þe aclesian ATTENDING PHYS. page DIRECTOR PHYS. FUNERAL 22€. PHYSICIAN'S 22d. ADDRESS should be director, NAME (Type) Dr. James Hallinan 10 Bedford St., Cumberland, Mc. 23a. BURIAL, CREMATION. 23b. DATE THEREDE 23c. NAME OF CEMETERY OR CREMATORY 23d. LDCATION (City, town or county) (State) REMOVAL (Specify) .Savage Meth.Cem/ Mt. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. SOWERS, HAFER-SOWERS ST. FROSTE VR A15 (4) 2DM 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o COLINTY Deportment of urs after death 0 ALIEGANY
b CITY OR TOWN (If outside corporate limits, MARYLAND MARYLAND ALTEGANY C LENGTH OF STAY IN 10 c (ITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and a ve nearest town) CUMBERTAND

d STREET ADDRESS CUMBERLAND DIFFE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENC fote Deg Office along with form ON A FARM? Item 18. Give Pages 188 N. CENTRE ST YES NO XX 188 N. CENTRE ST hours ofter deoth 3 NAME OF F+rs1 Middle DATE the Si Dov DECEASED (Type or print) George Edwin DEATH March 5 SEX IF UNDER 1 YEAR 6 COLOR OR RACE AGE (In years 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH lost birthdov) Months Dovs Hours WIDOWED DIVORCED event MATE WHITTE Do USUAL OCCUPATION (Give kind of work done Ob KIND OF BUSINESS OR 11 BIF HILACE (State or foreign country) 2 CIT ZEN OF WHAT during mast of warking the even if retired)
YARD CONDUCTOR (R RATLROAD COUNTRY? any d "pending" in pencil in Chief Medical Examiner's MARYLAND USA pencil 13 FATHER'S NAME be executed within 14 MOTHER'S MAIDEN NAME HENRY W. PARKER puo JANE ANN WHITE IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address or removal, (Yes, no, or unknown) ((If yes give wor or dotes of service) 705 09 3688 GEORGE C. PARKER, POTOMAC PARK, CHMBERLAND, MD 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c)) NTERVAL BETWEEN PART I DEATH WAS CAUSED BY. Sudden Coronary Occlusion IMMED ATE CAUSE (a)_ certificate shauld crematian, DUE TO Conditions if any, which gove Coronary Sclerosis forwarded to rise to immediate couse (a). DUE TO stoting the underlying couse used as buriof, c last PART I OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (o) 19 WAS AUTOPS PERFORMED? NO X 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of tem 18) PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While factory, street, office bldg , etc.) moy be retained for your FUNERAL DIRECTOR: Page of work of work 21 I certify that I taak charge of the remains described above, held an Autopsy [], Inspection [X], Inquiry [X], and in my opin an death resulted fram Natural causes XX, Accident , Suicide , Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER **SIGNATURE** O DEPUTY 5 DEPUTY MEDICAL EXAMINER X 12, 1967 March **EXAMINER'S** 5 moy b ro FUNES Health o Address (Street, city, town, or county Cumberland, Manyland Benedict Skitarelic, M.D. NAME (Type) 230 BURIAL, CREMATION 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) REMOVAL (Specify)
BUR TAL CUMBERLAND, MD. MARCH 15,1961 GREENMOUNT CEMETERY 24 FUNERAL DIRECTOR BYRON ADDRESS 250. REC'D BY REGISTRAR 25b REG STRAR'S SIGNATURE KIGHT VR AISME (5) CUMBERLAND, MD. 15 6M 1/66



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02985 requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY ALLEGANY b. COUNTY VIRGINIA MARYLAND completely filled in by the flower carbon papers. Pages c (ITY DR TOWN (If autside corporate limits, write RURAL and give negrest town) b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 write RURAL and give nearest tawn) PAW PAW DAYS CUMBERLAND a NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d STREET ADDRESS IS RESIDENCE hin 72 | DN A FARM? ROUTE MEMORIAL HOSPITAL YES NO [3 NAME OF Middle Lost 4. DATE Year 6 remove carbon MARCH DECEASED PLATT C. JOHN 19 DEATH event, (Type or pant) AGE (In years IF UNDER 24 HRS S. SEX 6 (OLOR OR RACE 7. MARRIED 8 DATE OF BIRTH IF UNDER 1 YEAR **NEVER MARRIED** dst pirthdoy) Months Hours 4-23-06 WHITE MALE WIDOWED DIVORCED ond in an 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY KEIFER. MD Kellv Tire Co. Inspector 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME buriol, cremotion, or removal, SLIDER, NANCY ELLEN WILLIAM PLATT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY ND 17 INFORMANT Address buriol-transit permit. (Yes, na. or unknown) (If yes give war or dates of service) CUMBERLAND, MD. MEMORIAL HOSPITAL. 214-07-0695 INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per ling-for (a), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. signed by estive failure DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying cause os the prior to b O FUNERAL DIRECTOR: After this certificate hos been last. PART II OTHER SISSIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) WAS AUTOPSY PERFORMED? 3 should be detached for use with the State Dept. of Health p NO 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour o m. factory, street, office bldg., etc.) Not While ot work 21. I certify that (1) (this haspital) attended the deceased fram 10.17.5%, 196:20a P. M. 3. 1967, and that death accurred at M. from causes and an the date stated above saw the deceased alive an. 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** DIRECTOR PHYS. director, page 3 should be filed v PHYS. 22d. 22c. PHYSICIAN'S WBERLAND, MARYLAND NAME (Type) 23d LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION DATE THEREOF (County) (Stote) REMOVAL (Specify) Va. Sulphur Springs Cem. Paw Paw. 25b REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR 24. FUNERAL/DIRECTOR VR A15 (4) 20 M 1/66 Berkeley Spgs.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02986 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH n. COUNTY o. STATE b. COUNTY ALLEGANY MARYLAND MARYT.AND ALLEGANY b CITY OR TOWN (If outside carparate limits. C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
FROSTBURG requires that the death certificate be executed within 24 hours FROSTBURG oon papers within 72 ha d NAME OF HOSP TAL OR INSTITUTION (if not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENC ON A FARM MINERS HOSPITAL NO TY 38 MESHACK FROST YES physician and campletely fine please reprave carbon 3 NAME OF Middle DATE First Lost Doy Year DECEASED MARY V. PUGH MARCH 19 67 (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED NEVER MARRIED I last birthdoy) Months Dovs Hours PEMATE WHITE MARCH 16. WIDOWED DIVORCED 1901 10o USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT and in COUNTRY? during most of working life, even if retired)
HOUSEKEEPER MARYLAND HOMES II.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME RICHARD A. PUGH SARAH FREAL IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 215-48-2666 WM. F. PUGH. FROSTBURG. MD. RT. 1, BOX 48 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)
PART I. DEATH WAS CAUSED BY: NTERVAL BETWEEN ONSET AND PEATH burial-transit IMMEDIATE CAUSE (o DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying couse the O FUNERAL DIRECTOR: After this certificate has been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Health r USe YES [NO Ę 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Doy, Year 204 INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (Stote) (County) factory, street, office bldg., etc.) Hour o.m. Not While of work 21. I certify that (1) (this hospital) attended the deceased fram march 15, 1967, to march 22, 1967 that (1) (we) last be retained march 121967, and that death accurred at 25 M, fram causes and an the date stated above. saw the deceased alive an 22o, SIGNATURE 22b. DATE SIGNED ATTENDING PHYS STAFF PHYS. DIRECTOR **ADDRESS** 22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS. M. D. BROADWAY. FROSTBURG. director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION 23b DATE THEREOF (County) (Stote) BURIAL (Specify) MAR. 25 ST. MICHAEL'S CEMETERY 167 FROSTBURG, MD ADDRESS 2So REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) JOSEPH R. DURST, SR., FROSTBURG, MD. 20 M 1/66

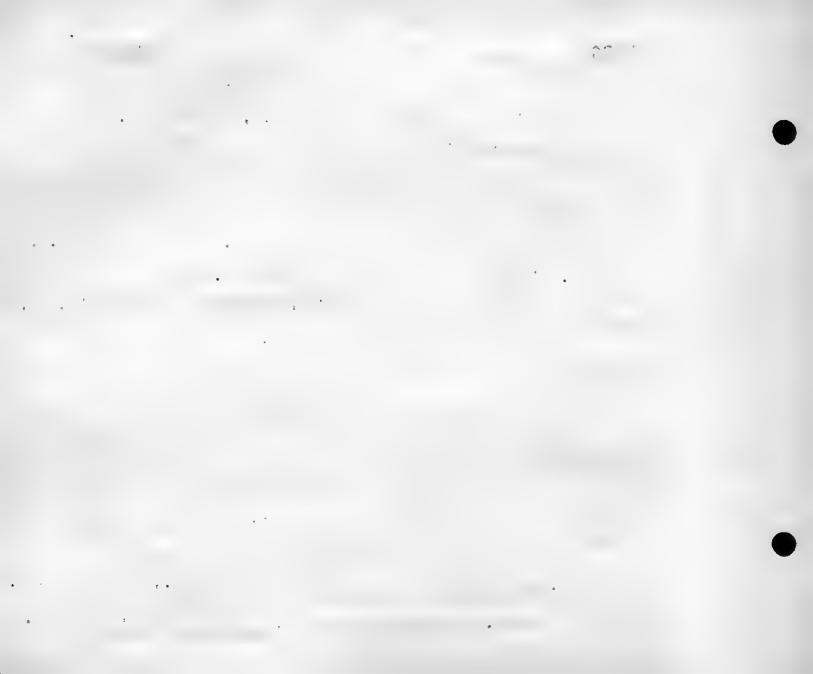


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02987 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 havrs after death One ra 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) O. STATE MARYLAND a. COUNTY **b.** COUNTY ALLEGANY MARYLAND ALLEGANY b CITY OR TOWN (If autside corparate limits, c CITY OR TOWN (If autside corporate lemits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 CUMBERLAND DAYS filled in e. IS RESIDENCE ON A FARM? burial, cremation, or removal, and in any event, within 72 h d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 511 MARYLAND MENORIAL HOSPITAL NO X signed by the attending physician and completely f burial-transit permit. Then please remave carban 3 NAME OF Middle First 4. DATE Month Last Day Year DECEASED ELIZABETH B. RAVENSCROF MARCH 20 1067 (Type or print) DEATH 5. SFX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years **NEVER MARRIED** lest b rthday) Davs Hours FEMALE WHITE 11-13-1880 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done duri**្រុំ ក្រសួងស្វា**បរា**ងក្នុំ ប្រាក្**ទេបen if retired) 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? INDUSTRY WHEELING. W. VA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WILLIAM KALBAUGH BERTHA LANDKROHN 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, na, or unknown) ((If yes give wor or dates of service CUMBERLAND. MEMORIAL 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).
PART | DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to lost. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Nat While Hour o.m. factory, street, affice blda., etc.) ot wark 21. I certify that (I) (this haspital) aftended the deceased from 12: 05 from Jauses and on the date stated above. and that death occurred at saw the deceased afive on. 220. SIGNACURE 22b. DATE SIGNED **ATTENDING** DIRECTOR M.D. PHYS 22d. ADDRESS 227 PHYSICHAN'S NAME (Type) G. HADMELWRIGHT FIRGINIA AVE. 236 DATE THEREOF 23d LOCATION (City or Town)
Westernport 230 BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY Md. (Stote) (County) 3/23/67 BMOVE (SPECIFY) Philos **ADDRESS** 25g REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Westernport, Md. VR A15 (4)

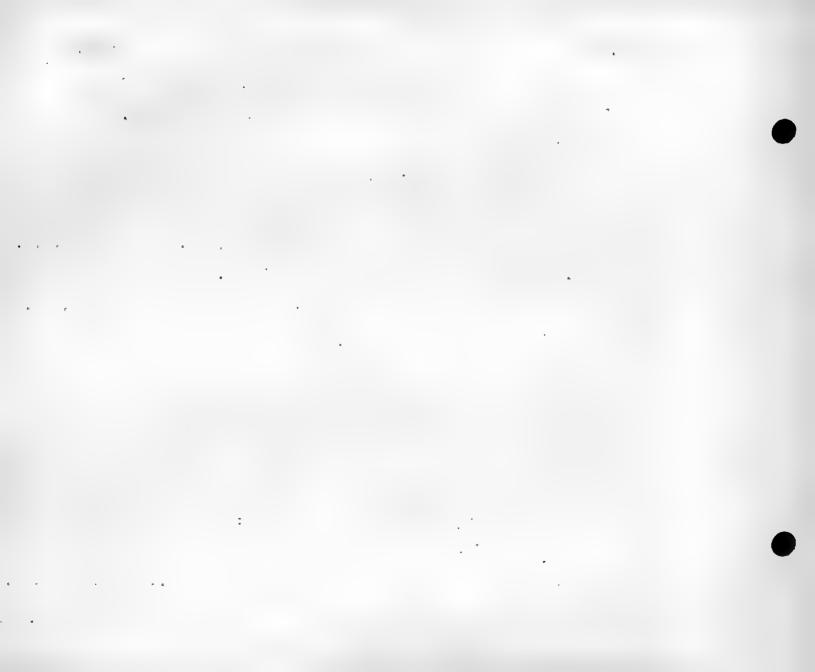
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH by the funeral Pages 1 and 2 tours after deoth. law remuires that the death certificate be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission o. COUNTY ALLEGANY **b** COUNTY BEDFORD PENNA. MARYLAND b CITY OR TOWN (If outside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Write RURAL and give nearest town)
CUMBERLAND BOX 462. HYNDMAN. PA. HRS filled in I d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL YES NO IX 3 NAME OF Middle Lost 4. DATE Month Doy Year DECEASED JERRY LYNNRINGLER 19 67 BABY MARCH BOY 6 (Type or print) DEATH F UNDER 1 YEAR IF UNDER 24 HRS. SEX B. DATE OF BIRTH 9. AGE (in years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** lost birthday) Doys Hours 3-6-67 MALE WHITE WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 10o LSLAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY U.S.A. CUMB, MD. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME buriol cremation or removal. BRENDA L. STUBY ROBERT L. RINGLER IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) MEMORIAL HOSPITAL CUMBERLAND. MD. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (t)) INTERVAL BETWEEN signed by the buriol-tronsit p ONSET AND DEATH PART I, DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Page 4 moy be retained by the hospital or ottending physicion. DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO for use as the L f Health priar to b stating the underlying couse this certificate hos been 19. WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO YES | 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH director, page 3 shauld be detached should be filed with the State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED foctory, street, office bldg., etc.) Not While at work TO FUNERAL DIRECTOR: After director, page 3 shauld be a 21. I certify that (1) (this hospital) attended the deceased from 9 ta_____, 19___, that (I) (we) lost M, from causes and on the date stated above. ., 19...., that (I) (we) lost sow the deceased dive on Shandly 19 U and that death occurred at 220_SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. ATTENDING M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S 401 DECATUR ST., CUMBERLAND, MD. NAME (Type) LELAND RANSOM 23d LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. 8UR AL, CREMATION (County) (Stote) Buffalo Mills, Bedford Co.Pa Buria (Specify) 1967 Madley Cometery March 8. 250 MACRBY REODTRAD67 VR A15 (4) Hyndman. Pennsylvania 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours ofter death. puo 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) filled in by the funeral papers. Pages 1 and 1. PLACE OF DEATH a. COUNTY b. COUNTY ALLEGANY BEDFORD MARYLAND c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b CITY OR TOWN (If outside carporate limits 1岁 HRS BOX 462, HYNDMAN, PA. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS HOSPITAL MEMORIAL YES | NO 30 3 NAME OF First Middle Last 4. DATE Manth Dov Year attending physicion and completely bermit. Then please remove carbon DECEASED OF MARCH 67 BABY BOY TERRY LEE RINGLER 6 (Type or pnnt) DEATH ond in ony event. 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 7 MARRIED NEVER MARRIED last birthday) Hours WHITE MALE 3-6-67 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a USJAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) during mast af warking life, even if retired) INDUSTRY COUNTRY? U.S.A. CUMBERLAND. MD. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removol, ROBERT L. RINGLER BRENDA L. STUBY IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) CUMBERLAND, MD. MEMORIAL HOSPITAL burial, cremation, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-tronsit p ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (o). DUE TO for use as the t fHealth prior to b stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CERTIFICATION NO YES 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (AUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year foctory, street, affice bldg., etc.) Not While 19 :P., ta_ , and that death accurred at 3 21. I certify that (1) (this haspital) attended the deceased fram 19___, that (I) (we) last ploods M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a SIGNATURE ATTENDING STAFF PHYS. M.D. PHYS. DIRECTOR 22d. ADDRESS PHYSICIAN'S LELAND RANSON DECATUR ST., CUMBERLAND, MD. NAME (Type) director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) 23b. DATE THEREOF 23g BURIAL CREMATION. REMOVAL (Specify) Buffalo Mills, Bedford Co. Pa Madley Cmetery 2Sb. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR 24-7EMNERAL DIRECTOR VR A15 (4) DMAR Hyndman, Pennsylvania 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a STATE b. COUNTY Allegany Allegany Marvland MARYLAND Department after death. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Oldtown Cumber land d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? State | Memorial Hospital Route Box 187 No F YES 4 hours after death. If any del. Item 18. Give Pages 1, 2, and Iffin along with Torm PM3. 3. NAME DE First Middle Last 4. DATE Month Year the 72 I DECEASED (Type or print) DEATH Phoebe Robertson 19 67 Florence March 2 with within 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months | Dave | Mours | Min 7. MARRIED X NEVER MARRIED Months Days White 6/11/1892 Female WIDOWED [DIVORCED [L-and 2 1Da. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12, CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Housewife Maryland
MOTHER'S MAIDEN NAME TISA pages in any 13. FATHER'S NAME EXAMINER: This certificate should be executed within 24 houng certificate, writing the word "pending" in pencil in Item should le forwalled to the Chief Medical Examiner's Office files. Emory Wilson Dora Leskia Athey and and 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 17. INFORMANT Routes1, Box 187 (Yes, no, or unkown) | (If yes give war or dates of service) permit. I removal, Oldtown, Maryland No Theodore R. Robertson 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) burlal-transit g cremation, or r Gengrene of Bowel DUE TO Thrombosis Mesenteric 30 Hours Conditions, If any, which (b). gave rise to immediate DUE TO cause (a), stating the Arteriosclerosis 603 underlying cause last. used as to burial, PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY CERTIFICATION PERFORMED? YES TY NO 3 should be a agent, prior t 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of Item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE DF INJURY (Home, farm,) 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour e.m. Not While at work at work Inspection 7, 21. I certify that I took charge of the remains described above, held an Autopsyxxx. Inquiry by), and in my ppinion FUNERAL DIRECTOR: Health or its design Undetermined manner death resulted from: Natural causes X Accident Suicide Homicide CHIEF MEDICAL EXAMINER director. Mage 4 retained for your 22. DATE SIGNED SIGNATURES DEPUTY MEDICAL EXAMINER X March 16, 1967 **EXAMINER'S** Benedict Skitarelic. M.D. Address (Street, city, town, or countyCumberland. Md. NAME (Type) BURIAL CREMATION, 23b. DATE THEREOF BURIAL (Specify) 3/10/67 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 0 40 19/67 Near Oldtown Greenridge Cemetery Md. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS 25a. 25b. REGISTRAR'S SIGNATURE VR AISME (5) Balto Ave. Cumberlandare 1/65



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY by the f Pages 1 irs after b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Allegany MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENCTH OF STAY IN 1b n and completely filled in by remove carbon papers. Pagin any event, within 72 hours Cumberland Cumberland Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET, ADDR IS RESIDENCE ON A FARM? 217 Maryland Avenue NO Y YES [217 Maryland Avenue 共產務的被對於 certificate be executed within NAME OF First Middle DATE Year Last 4. Month Day DECEASED (Type or print) Matilda Evelvn DEATH 19 67 Robinette March 6. COLOR OR RACE | 7. MARRIED ACE (in years | IF UNDER 1 YEAR | IF UNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. 5. SEX 8. OATE OF BIRTH NEVER MARRIEO [Female White WIDOWED X OIVORCED | May 10. 1876 90 YTS. attending physician a ermit. Then please rain, or removal, and in 10a. USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired) 10b. KIND OF BUSINESS OR 1NOUSTRY 12. CITIZEN OF WHAT 11. BIRT HPLACE (County & State, or foreign country) COUNTRY? Housewife Near Fairview IIS.A 13. FATHER'S NAME William Fletcher Nancy Jane Weimer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Cumber landMo (Yes, no. or unkown) \((If yes pive war or dates of service) d by the att transit perm cremation, (218-16-2647 Mrs. Rhea Bolinger, 217 Maryland A VO INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] been signed by the burial-transit or to burial, crems PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) nemaca attending physician. wes 5 DUE TO Cenditions, If any, which (b) gave rise to immediate OUE TO cause (a), stating the as th underlying cause last. CERTIFICATION WAS AUTOPSY PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO CEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use for use Health PERFORMED? NO A YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. OESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of Item 18.) 5 S MEDICAL (State) 20c. TIME OF INJURY Month, Oay, Year (County) 20d. INJURY OCCURREO | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. Not While While at work at work should ith the S 21. I certify that (!) (this hospital) attended the deceased from DIRECTOR: age 3 should led with the saw the deceased alive on the 19 and that death occurred at M. from the causes and on the date stated above. 22a. SIGNATURE 22b. OATE SICNED DIRECTOR __ M.D. O HOSPITAL FUNERAL PHYSICIAN'S 22d. ADDRESS 22c. director, p NAME (Type) Clay E. Durrett (State) BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) Greenmount Cemetery Cumberland, Maryland 67 24. FUNERAL OIRECTOR **ADDRESS** 25a. REC'D BY RECISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 (4) Cumberland to Ave. 20M 1/65

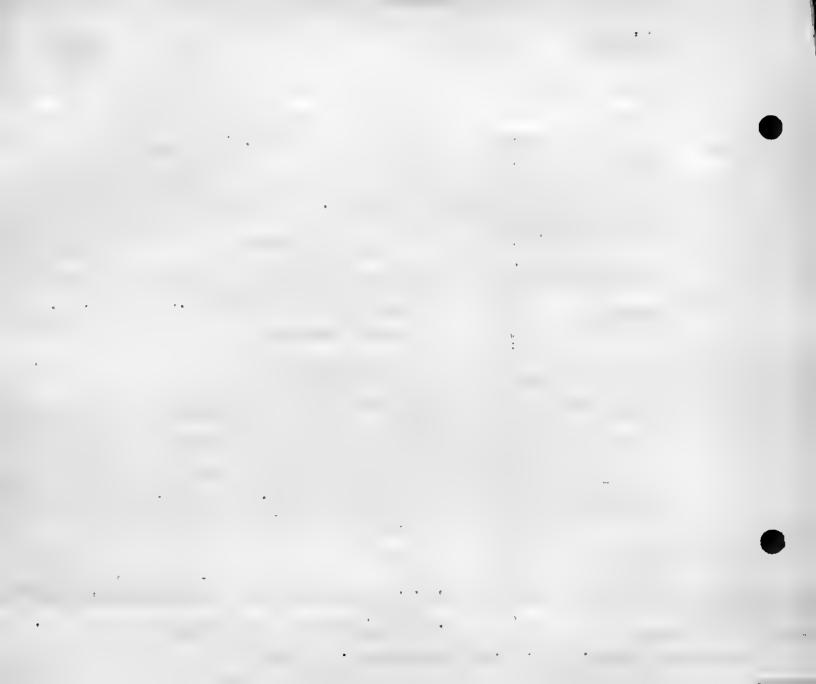
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02992 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before o COUNTY **b** COUNTY ALLEGANY VIRGINIA MINERAL MARYLAND requires that the death certificate be executed within 24 haurs after campletely filled in by the b CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) CONBERD GIVE POOLEST TOWN) KEYSER DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? ROUTE MEMORIAL HOSPITAL YES NO T remave carban i 3 NAME OF First Middle 4. DATE Lost Month Doy Year DECEASED MARCH 19 67 CONRAD ROBY (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH log pythdoy) Months Days Hours 11-25-86 WHITE MALE and in any WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY 3 W. VIRGINIA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, or remaval, BENJAMIN ROBY ELIZABETH POWELL 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address CUMBERLAND, MD. MEMORIAL HOSPITAL INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician. 11201 DUE TO Conditions, if any, which gove (b) rise to ammed ote couse (a), DUE TO stating the underlying couse as the prior tak has been tost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS PERFORMED? be detached for use State Dept. of Health r this certificate h detached far use YES 🗀 NO 20b, DESCRIBE HOW INJURY OCCURRED, (Errer noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While ot work 19 ot work O FUNERAL DIRECTOR: After director, page 3 shauld be c 21. I certify that (I) (this haspital) attended the deceased fram. 19 6) that (I) (we) last director, page 3 shauld should be filed with the saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. ঘ DIRECTOR M.D. PHYS MD= 22d. ADDRESS 22c. PHYSICIAN'S 414 N. DOERNER MECHANIC ST. CUMBERLAND. - NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL CREMATION 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) 20 Mar 1967 Biertown Allegany Co. Md. 256 REGISTRAR S-SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR Marley VR A15 (4) 20 M 1/66 Keyser, W. Va.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 02993 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY **b** COUNTY ALLEGANY ALL EGANY MARYIAND c CITY OR TOWN (If garside carparate limits, write RURAL and give nearest town) b CITY OR TOWN 11f autside carparate limits c. LENGTH OF STAY IN 16 requires that the death certificate be executed within 24 hours of CUMBERLAND. MD. HR. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 100 PENNA. AVENUE ON A FARM? MEMORIAL HOSPITAL NO 🛣 3 NAME OF First 4. DATE Last DECEASED ROOT LAKIN MARCH (Type or print) DEATH 8. DATE OF BIRTH S. SEX 6 COLOR OR RACE 7. MARRIED AGE (In years NEVER MARRIED last birthday) MALE WHITE 12-28-10 WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR U.S.A. PRESTON CO, W. VA. INN MANAGER 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ALICE SANHAM SHANAN WILLIAM ROOT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, ng. ar unknown) (If yes give war ar dates of service) CUMBERLAND, MD. MEMORIAL HOSPITAL 217-10-1019 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY-INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise ta immediate cause (a), DIJE TO stating the underlying couse PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? Wyora- gland NO 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of Item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) at work TO FUNERAL DIRECTOR: After from 1930 to 30P M, from causes and an the date stated above. 21. I certify that (1) (this haspital) attended the deceased from saw the deceased alive on 22a. SIGNATURE MED. DIRECTOR 225 9DORES REENE ST., CUMBERLAND, MD. 22c. PHYSICIAN'S DR. S. G. WEISMAN NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23a BURIAL CREMATION 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) NEAR CUMBE LAND ALLEG MD HILLCREST BURIAL PARK 3/19/67 **ADDRESS** 2Sb. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR VR A15 (4) Balto Aval. Cumberland, Md DAMAAR 2 Hafer:



	MARYI Division of STATISTICAL RESEARCE	AND STATE D	Mr. 2-412 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	OF HEALTH ON STREET, BALTIM	ODE 1 MADVI	AND
FOR STATE		EXAMINER'S		TE OF DEATH		C
FALTH DEPK	1. PLACE OF DEATH		2. USUAL RESIDEN	CE (Where deceased lived, If	institution: Residence to	elore admission)
8 . 5 1/7	a. COUNTY		e. STATE	vland b. cou		
Tiles of Tiles	b, CITY OR TOWN (if outside corporate limits, c.	MARYLAND LENGTH OF STAY IN 16		If outside corporate limits, writer		
in any de cy is incossary, the funeral director. Page refained for your files, he State Department of wurs after death,	write RURAL and give nearest town)				- 7	1 1
direct your sath, sath,	Frostburg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite).	DOA give street eddress)	d. STREET ADDRESS	stburg,	1.4	. IS RESIDENCE
	Miners Hospital			W. Main		ON A FARM?
on State	3. NAME OF First DECEASED	Middle	Lesi	4. DATE Mont	th Dey	Aget
2	(Type or print) Frank		Ruffo	DEATH Merc	h 24th,	1967
7	5. SEX 6. COLOR OR RACE 7. MARRIED	NEVER MARRIED B.	DATE OF BIRTH	9. AGE (In yeers last birthday)		UNDER 24 HRS.
\$ 17 \$ 18	Male White WIDOWED TO	DIVORCED T	Teb. 25th,18	94 73 yrs.	Months Days H	ours Min.
within	10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Stote	or foreign country)	12, CITIZEN OF W	HAT COUNTRY?
~ +=	m 1 f 7 m 1	avern	Marylan	đ	US	A
pages	13. FATHER'S NAME		14. MOTHER'S MAIDEN	NAME		
rije p	Antonio Ruffo		Rosina M	orro		
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC (Yes, no, or unkown) (Ifyes give weror detes of service)	IAL SECURITY NO. 17. II	NFORMANT	Addres	is .	
permit.		32-2802 Ca	rl Ruffo, F	ederal St., Fr	rostburg. Mo	d.
al, a	18. CAUSE OF DEATH [Enter only one cause per line for		,		1 INTERV	AL BETWEEN
Busi	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Ruptured	Aorta		Min	and DEATH
burial-transit perm	82.34 DUE TO					
0	Conditions, if any, which 7 (b)	Crushed	Chest		Suc	dden
cremation	geve rise to immediate cause (e), stating the underlying DUE TO					
e E	enuse fest. (c)					
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB	UTING TO DEATH BUT NO	T RELATED TO THE TERMI	NAL DISEASE CONDITION GI	VEN IN PART 1(e) 19.	WAS AUTOPSY PERFORMED?
r to burial,	5				YES.	
2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB 20a. EXTERNAL CAUSE WAS PRIMARY-M or CONTRIBUTING 20b. DESCRIBE P	HOW INJURY OCCURRED.	Enter nature of Injury in I	Pert I or Pert II of item 18.)		
	DITAG	r of Car which	h Crashed i	nto a tree		
ď.		Not White 5	CE OF INJURY (Home, ferr		(County)	(State)
agent, prior	5:00 March 24 1967 of work	al work X 12 We	st Main St.	Frostburg,	Allegany, 1	Maryland
9	21. I certify that I took charge of the remain:	s described above, hel	d an Autopsy 🟋.	Inspection X, Inqui	iry 🔼 and in	my opinion
9	death resulted from: Natural causes	Kooldent 🔽. Suici	de . Homicide	Undetermined	manner 🔲	
ign	1 1	Vo /	CHIEF MEDICAL	EXAMINER [
<u> </u>	ACTUAL SIGNATURE SECURICAL	He Tarele	ASSISTANT MED	DICAL EXAMINER [DAT	E SIGNED
E SE			DEPUTY MEDICA	L EXAMINER March	1 24, 1967	
4 should be lorwarded to the TO FUNERAL DIRECTOR: Pa Health or its designated agent.	NAME (Type) Benedict Skitareli	c, M.D.	Address (Street,	city, town, or county) Cumb	perland, Ma	ryland
日青	22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify)	. NAME OF CEMETERY OR	CREMATORY	22d. LOCATION (City, tow	n, or county)	(Stete)
ဝူနို		t. Michael's	Cemeterv	Frostburg		md.
	23. FUNERAL DIRECTOR	ADDRESS	24m. RE	W.	GISTRAR'S SIGNATURE	se.
115ME	Joseph R. Durst, Sr.	Frostburg, Mo	1. INTAR	28 1967 4	In Some	7
1/63						
1						



DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 1 2. USUAL RESIDENCE (Where decreased lived, If institution, Residence before admission) e. COUNTY a. STATE **b.** COUNTY ALLEGANY MARYLAND ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest fown) write RURAL end give nearest lown) CHMBERLAND CUMBERLAND d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street a Idress) d STREET ADDRESS a. IS RESIDENCE ON A FARM? 2 with the State In 72 hours after of 208 CHARLES STREET 208 CHARLES STREE YES NO X NAME OF M ddla 4. DATE Month Day DECEASED OF (Type or print) DEATH Julia Rydahl March 19 67 6. COLOR OR RACE T. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years) IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days Hours DIYORCED TOV. WIDOWED Y 24,1888 FEMALE Vrs. 1, 2, a ge 5 and 3 1Da USJAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Give Pages 1, 2, rm PM3. Page 1 12 CITIZEN OF WHAT COUNTRY? done during most of working life, even if ratired) DRESSMAKER SELE EMPLOYED MICHIGAN TISA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME PETER HANSEN ANNA JOHNSON 15 WAS DECEASED EVER NU.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Addrass (Yes, no, or unknown) I (If yas give war or datas of service) LILLIAN YATES. CUMBERLAND, MD. 18. CAUSE OF DEATH [Enter only one cause per line for (a), b], and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Sudden Office burial-t DUE TO Conditions, if any, which Sclerosis Coronary gave rise to immediate cause word "pending dical Examiner" DUE TO (a), stating the undarlying PART II. OTHER SIGN FIGANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 19. WAS AUTOPSY CERTIFICATION 2 PERFORMED? the word NO X 20b DESCRIBE HOW INJURY OCCURED (Enter nature of in ury in Part I or Part II of Item 18) 20s. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. Chief / MEDICAL Month, Day Your | 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town, 20c. TAME OF INJURY (County) (Stata) factory, straet, office bldg , etc] While Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection 😿 Inquiry X and in my opinion death resulted from-Natural causes XX Surcide Acc dent Hom'cide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL. should be for FUNERAL 1 ASS STANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY DEPUTY MEDICAL EXAM NER March 11. EXAMINER'S NAME (Typa) Benedict Skitarelic, M.D. Address (Stree', city town or county) Cumberland, Maryland 22c. NAME OF CEMETERY OR CREMATORY | 22d TOCATION (City, town, or country) (\$ ata) 22e BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Spacify) <u>9</u>40 j MARCH 14,196 BURIAL GRAND RAPIDS. MICHIGAN 248 REC'D BY REGISTRAR I YR ATSME BYRON KIGHT CUMBERLAND, MD. 5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 92996 CERTIFICATE OF DEATH campletely filled in by the funeral nove carbon papers. Pages 1 and 2 by event, within 72 hours after death requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND ALLEGANY MARYLAND b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL pind the modresh town CUMBERLAND 3M0 12 DA. d NAME OF HOSPITAL OR INSTITUTION (15 not in hospital, give street oddress)

MEMORIAL HOSPITAL d. STREET ADDRESS ON A FARM3 49 N. MECHANIC 3 NAME OF 4. DATE First Middle Lost Month Doy Year DECEASED SCHELL DAYTON ALS TON 12 19 67 remove carb MARCH (Type or print) DEATH burial, crematian, ar remaval, and in any event, S. SEX 9. AGE (In years YEAR IF UNDER 24 HRS. 6 COLOR OR RACE NEVER MARRIED B. DATE OF BIRTH IF JNDER MALE WHITE -24-1895 lost birthdoy) Hours WIDOWED DIVORCED The JSUAL OCCUPATION (Give kind of work done pring most of working is away if retired). 11. BIRTHPLACE (County & Stote, or foreign country) 106 KIND OF BUSINESS OR 12. CITIZEN OF WHAT GOUNTRY ?A signed by the attending physician burial-transit permit. Then please MAYSVILLE.W. VA. 13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME SUSAN SEARS TAYLOR SCHELL WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, ng, or unknown) (If yes give wingor dates of service) MEMORIAL HOSPITAL, CUMBERLAND, MD. B CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c).
PART I. DEATH WAS CAUSED BY:
Presumonia INTERVAL BETWEEN ONSET AND DEATH (terminal) and Congestive Pneumonia 4 may be retained by the haspital ar attending physician. Heart Failure da ys DUE TO Prostatic Carcinoma with metastases Conditions, if ony, which gove rise to immediate couse (o), DUE TO 8 years to jungs and skeleton stoting the underlying couse director, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES 🗀 NO 2Do ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) While at work at work 21. I certify that (I) (this hospital) attended the deteased from NOV. 24th, 1966, to March 1219 67that (I) (we) last saw the deceased alive on March 12thy 67 and that death occurred at 1:55%; from causes and an the date stated above. -22a-SIGNATURE 22b. DATE SIGNED 3-14-67 **ATTENDING** MED. DIRECTOR X M.D. 22d. ADDRESS 224_PHYSICIAN'S -NAME (Type) N.MECHANIC ST. CUMBERLAND, MD. DOERNER WYAND M.D. MAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 23b. DAJE THEREOF 23d. LOCATION (City or Town) 25o. REC'D BY REGISTRAR VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR S PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY Alleganu a STATE 5 COUNTY Poge 0 death. Maryland Allegany MARYLAND Deportment b CTY OR TOWN (If autside carporate limits, c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) C LENGTH OF STAY IN 16 rite RURAL and give negrest town) Cresaptown. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS S RESIDENCE ON A FARM? hours D. O. A. Sacred Heart Hosp. Winchester Rd. Item 18. Give Poges NO X hours after deoth 3. NAME OF First Middle Inst Month Year Doy DECEASED Virginia Annie Shank March 20. 67 19 DEATH S SEX 6 COLOR OR RACE 7 MARRIED B DATE OF BIRTH 9 AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED Female White lost bythdoy) Months Haurs Sept. 5. 1882 WIDOWED DIVORCED Te e Ment 100 USUAL OCCUPAT ON (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (State or fareign country) 12 CT ZEN OF WHAT during most of working life, even if retired) Own home COUNTRY'S. A. Augusta. W. Va. .⊑ Onv Examiner's pages 13 FATHER S NAME pencl 14. MOTHER'S MAIDEN NAME be executed within .⊑ David Wright Elizabeth Anderson and 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16, SOC AL SECURITY NO 17. INFORMANT Md. Address (Yes, no. ar unknown) ((If yes give war ar dates at service) removol. None Miss Nina L. Shank Winchester Rd. Cresaptown, 1B CAUSE OF DEATH (Enter only one couse per line for (a) (b) and (c)) INTERVAL BETWEEN PART DEATH WAS CAUSED BY ō CORONARY OCCLUSION IMMEDIATE CAUSE (o) This certificate should e, writing the word forwarded to the Ch cremotian, DUF TO CORONARY **SCLEROSIS** Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying cause 9 burial, 1 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY CERTIFICATION PERFORMED? NO K pleose execute the certificate, 10 20a EXTERNAL CAUSE WAS PRIMARY III OF CONTRIBUTING II 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of niury in Part I or Part II of item 18.) ogent, priar should CAUSE OF DEATH 20c TIME OF INJURY Month, Day, Year 20rd INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) FUNERAL DIRECTOR: Page Not While 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X Ingairy X. and in my opinion death resulted from. Accident Natural couses X Suicide | Homicide Undetermined manner 3/20/67 CHIEF MEDICAL EXAMINER ACTUAL 22. D'ATE SIGNED ASSISTANT MEDICAL FXAMINER **SIGNATURE** O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Benedict Skitarelic, M. D. Cumberland. 10 FUNE Health NAME (Type) Address (Street, city, town, or county) 230 BURIAL, CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 3/22/67 Indian Mound Cemetery Hampshire. W. Romney. Va. 24. FUNERAL DIRECTOR 250 REC D BY REGISTRAR 2Sb REGISTRAR S SIGNATURE VR A15ME (5) H. Wayne George Cumberland. Maryland Melianella 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02998 PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) , 2, and J. Poge o. COUNTY **b.** COUNTY Allegany Ö Maryland Allegany MARY, AND b. CITY OR TOWN (If outside corporate mits, c LENGTH OF STAY IN 1b. c C TY OR TOWN (If outside carparate , in its write RURAL and give nearest town) wide RURAL and give negrest town) offer 90 years Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? hours in Item 18. Give Pages 1, Memorial Hospital 605 Virginia Avenue ate YES NO X Exominer's Office along with NAME OF Middle 4 DATE Month Lost Dov Year DECEASED John Within Shewbridge 22 (Type or print) March 67 DEATH IF UNDER 1 YEAR 6 COLOR OR RACE 9 AGE (In years F UNDER 24 HRS 7 MARRIED NEVER MARRIED B DATE OF BIRTH Months July 11, 1875 lost b rthdoy) Hours White Male hours WIDOWED TX and 2 event 10o USUA, OCCUPAT ON (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT dunga mast of working life, even if retired) COUNTRY? Harpers Ferry , W. Va. Co. USA poges I pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME This certificate should be executed within Benjamin C. Shewbridge Mary Margaret Finn ond 16 SOCIAL SECURITY NO 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Daughter Address rd "pending" in Chief Medical E permit. removal, (Yes, no, or unknown) (If yes give wor or dotes of service Mrs. Anna Mahaney Cumberland Md. no 1B CAUSE OF DEATH (Enter only one couse per ne for (o), (b) and (c).) INTERVAL BETWEEN **burial-transit** Days PART I. DEATH WAS CAUSED BY: Occlusion Coronary Ö IMMEDIATE CAUSE (o) e, writing the ward forwarded to the Ct buriol, cremotion, HdUI DUE TO Sclerosis with Thrombosis Coronary Conditions, if any, which gove (b) rise to immediate couse (a), DUE TO stating the underlying couse o lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? Lobar Pneumonia, terminal: Chronic Glomerulonephritis please execute the certificate, YES [NO 20p. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port I, of item 18) 3 should agent, prior PRIMARY I or CONTRIBUTING I AL EXAMINER: CAUSE OF DEATH 20c. TIME OF INJURY Month, Doy, Year 20d .NJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While may be retained for your FUNERAL DIRECTOR: Page ot work 21. I certify that I taak charge of the remains described above, held on Autopsy [X, Inspection X Inquiry X. and in my apinian death resulted fram. Natural causes X, Accident . Suicide . Hamicide Undetermined manner O DEPUTY MEDIC CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED 3-22-1967 ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Dr. Benedict Skitarelic, M.D. Rt.9 Cumberland NAME (Type) Address (Street city, town, or county) 23d LOCATION (City or fown) 23b DATE THEREOF 23t NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, (County) 500 REMOVAL (Specify) Mar. 24, 1967 Cumberland, Md. Allegany Hillcrest Burial Scarpelli, Cumberland, Md. 250 REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME (S)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 02993 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o STATE **L. COUNTY** Page Allegany 0 45 after death. Maryland Allegany MARY, AND delay b CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. gud write RJRAL and give negrest tawn) 1 Day Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS haurs form Sacred Heart Hospital 229 Baltimore Avenue YES NO DE **Give Pages** ate 24 haurs after death alang with 3 NAME OF Middle 4 DATE Month Dov Year DECEASED Cloyd THE THE STATE OF THE PERSON NAMED IN COLUMN TWO IN COLUMN (Type or print) Raymond Smith March 67 DEATH S SEX B. DATE OF BIRTH IF UNDER 24 HRS 6 COLOR OR RACE AGE (n years IF UNDER 7. MARRIED NEVER MARRIED last birthday) Manths Davs Hours Item 18 Male White WIDOWED DIVORCED February 21.1895 72 yrs Office even and 10a USUA, OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR .. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT Retired employee- B & COUNTRY? R.H. in any U.S.A Fairhope Pennsylvania Ξ. Chief Medical Examiners pentil 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME be executed within Harvey Smith Alice Martz gug 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. Address 119 Weber Street (Yes, no, ar unknown) (If yes give war or dates of service) remayal, Richard H. Smith Cumberland, Md 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY used as a burial trans burial, cremation, or Coronary Occlusion IMMEDIATE CAUSE (a) This certificate should 4001 DUE TO Conditions, if any, which gove Coronary Sclerosis rise to immediate cause (a). DUE TO stating the underlying cause lost. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19 WAS AUTOPS PERFORMED? YES**X X** NO the certificate, designated agent, priar ta 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port it of item 1B.) PRIMARY I or CONTRIBUTING I shauld CAUSE OF DEATH. WEDICAL 20c. TIME OF IN, JRY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm (City or fown) (Caunty) (State) Hour a.m. Not While factory, street, office bldg , etc.) DIRECTOR: Page at work at wark please execute Inspection X Inquiry X 21 I certify that I took charge of the remains described above, held an Autopsy [X] and in my apinian death resulted from: Natural causes X Accident Suicide . Homicide Undetermined monner the funeral director. be retained CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE may be re FUNERAL I March 1, 1967 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Benedict Skitarelic. O FUNE Health M.D. Address (Street, city, town, or coun Cumberland, Maryland NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION. 23d LOCATION (City or Town) (County) REMOVAL (Specify) 3/3/67 Cumberland Allegany Maryland
REGISTRAR 256. REGISTRAR'S SIGNATURE Greenmount Cemetery 2Sq. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5 MAR 3 1967 H. Lee Silcox Cumberland, Maryland 21502



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **FOR STATE** HEALTH DEPT PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o STATE Allegany b. COUNTY l 3 to Page Maruland Allegany MARY, AND b CITY OR TOWN (if outside carparate limits, write RUPAL and give necess town)

Cumberland r LENGTH DE STAY IN 1h c CITY OR TOWN (If outside corporate limits, write RURA, and give negrest town) Cumberland. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? D. O. A. Sacred Heart Hosp. 144 Polk St. YES NO K Mińdle First DATE Month within 72 DECEASED Tuson Marion Smoak March 19 67 (Type or print) DEATH 6 COLOR OR RACE IF UNDER I YEAR S SEX 8 DATE OF BIRTH 7 MARRIED NEVER MARRIED 9 AGE (In years .. NDFR 24 HRS White Malo lost birthdoy) Davs March 19, 1905 WIDOWED DIVORCED 10o USUA. OCCUPAT ON (Give kind of work dane during most of working life, even if retired)

Che f TOP KIND OF BUSINESS OR 11 BIRTHPLACE (State or fore an country) 12 CITIZEN OF WHAT COUNTRY? A. Restaurant Bamberg Co. S. C. d "pending" in pencil in Chief Medical Examiner's 14. MOTHER'S MAIDEN NAME pencil 13. FATHER'S NAME be executed within William B. Smoak Della Sandifer IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) remayal. No. 248-30-9008 Mr. Jones A. Smoak 608 N. 2nd St. LaVale, Md. INTERVAL BETWEEN
ONSET AND DEATH
Sudden 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 9 Coronary Occlusion, Left IMMEDIATE CAUSE (a) _ 4201 crematian, DUF TO Coronary Coronary Thrombosis. Left Conditions, if pay, which gove rise to immediate couse (o). DUE TO This certificate stoting the underlying couse Sclerosis Coronary PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? Left Ventricular Hypertrophy, Marked: Rheumatic Acrtic Stenosis YES X NO 20a EXTERNAL CALSE WAS 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of term 1B.) PRIMARY Or CONTRIBUTING CALISE OF DEATH 20c TIME OF IN. JRY Month, Day, Year 20d IN. JRY OCCURRED 20e PLACE OF INJURY (Home form (City or town) (Caunty) (State) Not While foctory, street, office bldg, etc.) FUNERAL DIRECTOR: Page ol work 21. I certify that I took charge of the remains described above, held an Autopsy inspection X. Inquiry 100 and in my opinion death resulted from: Natural couses XX. Accident Suicide [Homicide . Undetermined manner CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE' DEPUTY MEDICAL EXAMINER XX March 4, 1967 Health or **EXAMINER'S** Benedict Skitarelic, M.D. Address (Street, city, town, or co@trimberland. Maryland NAME (Type) 230 BUR AL, (REMAT ON, REMOVAL (Specify) Burial 23h. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 50 3/8/67 Denmark Cemetery Penmark, Bamberg, So. Carolina 24 FUNERAL DIRECTOR ADDRESS 2Sq REC'D BY REGISTRAR 2Sb REGISTRAR S SIGNATURE VR A15ME (5) H. Wayne George Cumberland. Md. Ochanles 1967 6M 1766



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02993 CERTIFICATE OF DEATH 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) and campletely filled in by, the funera o COUNTY ALLEGANY b. COUNTY MARYLAND MARYLAND ALL EGANY C LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, FROSTBURG (MT. SAVAGE) 11 DAYS san papers. within 72 ho e IS RESIDENCE ON A FARM? d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) MEMORIA HOSPITAL P.O. BOX 267 YES T NO requires that the death certificate be executed within 3. NAME OF Middle DATE remave carban Last Month Day Year DECEASED OF DEATH GEORGE SWEENE WHILIAM MARCH 10 1967 (Type or print) S SEX 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 1 IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED last birthday) 3-31-1885 MALE WHITE 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working ...te, even if refired)

COAL MINER COUNTRY? COAL MT. SAVAGE, MD. ÛSA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, WILLIAM H. SWEENE LILLIAN STEVENS 15. WAS DECEASED EVER IN ILS ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO 16-09-9238 HOSPITAL CUMBERLAND, MD. MEMORIAL crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter anly one cause per burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH ... IMMEDIATE CAUSE (o) þ DUE TO Conditions, if ony, which gave rise to immediate couse (a). DUE TO stating the underlying cause far use as the Health priar ta last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) this certificate has of Health NO YES T 20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part) or Part II of item 18.) directar, page 3 shauld be detache should be filed with the State Dept. 20e PLACE OF INJURY (Harne, farm, 20d. INJURY DCCURRED 20c. TIME OF INJURY Month, Day, Year (County) factory, street, affice bldg , etc.) Haur a.m. Nat While at wark TO FUNERAL DIRECTOR: After director, page 3 shauld be a 21. I certify that (I) (this hospital) attended the deceased from 2 and that death occurred at 2:25 Pm, from causes and an the date stated above. ne deceased alive an. 22b. DATE SIGNED STAFF M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 122 S. RICHARD WILLIAMS . MD. CENTRE ST. CUMBERLAND 23o, BURIAL, CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) REMOVAL (Speafy) **EUMBERLAND** 256 REGISTRAR SAIGNANIRE 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66



1			MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	RVI AND		
FOR S	7 *		03002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	12004		
HEALTH	DEPT.	1.		esidence before admission)		
e = 7×	t d	L	MARYLAND MARYLAND			
cessary, the funeral e 5 may be Department after death.		b. CITY OR TOWN (if outside corporate limits, write RURAL write RURAL end give nearest town) Westernport C. CITY OR TOWN (if outside corporate limits, write RURAL Westernport) Westernport	and give neerest town)			
the f the f Depar			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) d. STREET ADDRESS	e. IS RESIDENCE		
nd 3 to 1 Page . State D state D hours and		211 Spruce 211 Spruce	YES ND			
and 3.	इंट्र	3.	NAME OF First Middle Last 4. DATE Month OF OF OF OTHER WILLIAM TAYLORS DEATH MARA	Day Year		
1.2 1.2 1.2	雪人	5.	SEX I G. COLOR OR RACE I AMAROLED TO MARCHE TO LE DATE OF RIPLH 19 ACF (In years IFUNDER	30 19 67		
Pages 1,	2 3	M	Male Negro widowed Divorced Feb. 22, 1908 Syrs.	Deys Hours Min.		
= 6 =	l and event	1D: dur	a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 1.11, BIRTHPLACE (State or foreign country) 12, C	TIZEN OF WHAT		
rs after 18. Giv along		during most of working life, even if retired) Laborer Paper Mill Maryland U.S. 13. FATHER'S NAME				
	Dag III		William Taylor Mary Mitchell	,		
14 hm n Item Office	File and	15 (Ye	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT Address es, no, or unknown) (If yes give war or dates of service)			
ithin ncil i	permit. removal		no none John J. Taylor-westernport, Md.			
cuted gy" in Exar	r rer		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), end (c). 1 PART I. CEATH WAS CAUSED BY: Coronary Occlusion IMMEDIATE CAUSE (e)	ONSET AND DEATH		
	ransi on, o		April DUE TO			
"perlin Medical	rfal-t mati		Conditions, if any, which Coronary Sclerosos gave rise to immediate			
should "Chief N	427 00		cause (e), stating the OUE TO			
	ed as burial	NOI	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMEO?		
the the	\$ 5 ° °	CERTIFICATION		YES NO K		
100	thould be int, prior	ERTIF	2Ds. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH.	.)		
This cerate, writin	3 shou agent,	MEDICAL C	2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (Cou	inty) (State)		
ficate oe fo	6.6 8 8		Hour e.m. While Not While factory, street, office bldg., etc.)			
certi certi bud to s. Pag mate	: Pag gnate		21. I certify that I took charge of the remains described above, held an Autopsy, Inspection [x], Inquiry [x],	and in my opinion		
the cert	DIRECTOR: r its design		death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner			
ED Sute	or its		SIGNATURE Senedict Skilareliano ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED		
EXECUTE PAGE 1	글로우		EXAMINER'S Benedict Skitarelic	3/31/67		
please edirector.	FUNERAL Health o	238	BURIAL CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or con			
TO T			Burial (Specify) 4/2/67. Walden Westernport	Md.		
VR AI	SME (5)	24	(-12// /) / 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1			
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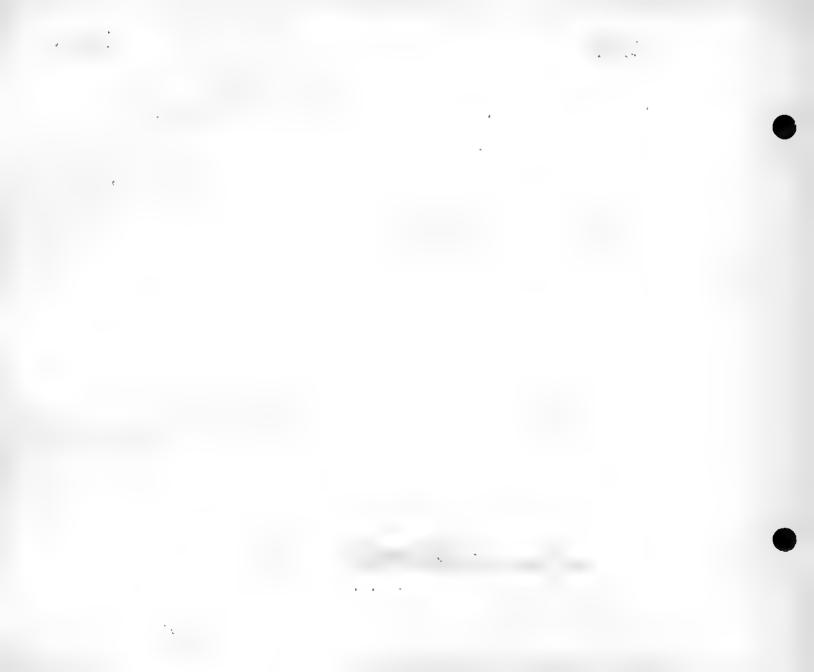


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ı	DIVISIO	N OF STATISTI	CAL RES	EARCH AND REC	DRDS	, 301 W. PRESTO	N STREET,	BALTIMOR	E 1, MA	RYLANI	D
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T	. PLACE OF DEAT a. COUNTY	H			1	2. USUAL RESIDENCE (Where deceased lived, 11 institution: Residence before admission)					
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	b. CITY OR TOW	N (if outside corpora and give nearest to	ite limits,	C. LENCTH OF STAY		c. CITY OR TOWN (If		to limits, write			
	CUMBERT A	מוי		19 Day	s	FLINIST	ONE			01.1	,
	d. NAME OF HO	SPÍTAL OR INSTITUTIO	ON (if not in	iress)	d. STREET ADDRESS				e. IS I	RESIDENCE A FARM?	
	SACRED	HEART HOSE	TPAL			ROU'E # 1				YES	-
3	. NAME OF DECEASED	F	Irst	Middle		Last	4. DATE OF	Month		Day	Year 🥎
	(Type or print)	ICTE		PEARL		TRAIL	DEATH	MARC	1 1	9 1	1968
5	. SEX	6. COLOR OR RACE	7. MARRIE	D X NEVER MARRIED		3. DATE OF BIRTH	9. AC	E (In years III st birthday) N	UNDER 1 Y	EAR IF UN	DER 24 HRS
	FEMALE	MALTE	WIDOWE			3-7-09	新洲	58 yrs.			
10a. USUAL OCCUPATION (Cive kind of work done during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country)									12. CITI	ZEN OF WI	HAT
	Hou	sewife				WESE VIRGINIA				U.S.A.	
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME											
WILT TAM WEAVIER ZELLA (DOLLY) ***********************************											_
Īċ	'es, no, or unkown)	EVER IN U.S. ARMED FO [(If yes give war or dates o	ORCES? 16 of service)	S. SOCIAL SECURITY NO.		INFORMANT		Address	Route	9]	
	No				3	PI'S CHARL	George_	Trail	Flir	itstor	ne Md
				line for (a), (b), and (c).	1					NTERVAL ONSET AN	BETWEEN
ł	PART I, DE	EATH WAS CAUSED BY IMMEDIATE CAUSE	(a)	ial failure					ays		
	4201	DUE	то								
	Conditions, If gave rise to		(b)	<u> Myocardial</u>	In:	farction				18 d	ays
	cause (a), si	tating the DUE	TO			44					
2	underlying caus		(c)	Coronary a							
ATIO	PARTIL OTHERS	SICNIFICANT CONDITION	ONS CONTRIB	BUTING TO DEATH BUT NO	TRELA	TED TO THE TERMINAL D	ISEASECONDIII	DŅ CIVEN IN PA	ART 1(a)	PERF	AUTOPSY ORMED?
191	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) 19. YES 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) (If EITHER, NOTIFY MEDICAL EXAMINER)									YES	NO 🎬
I a	OR CONTRIBUTI	ING CAUSE OF DEATHY MEDICAL EXAMI	TH NED	DESCRIBE HOW INJURI	OGGUI	KKED. (Enter nature of	injury in Part i	or Part II of I	(tem 18.)		
	1 '	INJURY Month, Day.		INJURY OCCURRED 120	No	ne G 05 IN INDX (II a control	rm.l 20f. (City		(Oaugh	4	(State)
MEDICAL	Hour a.m		While	Not While	factor	ne E OF INJURY (Home, fai y, street, office bldg., et	c.) 201. (City	or town)	(Count)	"	(State)
E p.m. 19 at work at work											
21. I certify that (I) (this hospital) attended the deceased from March 1, 1967, to March saw the deceased alive on March 19, 19,67, and that death occurred at 6.25m, from the									, 19 <u> 6</u> 1	(, that (I)	(we) last
ı	saw the dec		arch L	7, 19, 01, an	d that		PACM, NON		id on the 22b. DATE		ed above.
L	Jane		einas	1 ma			MED.	STAFF -	3~20 .		
K	M.D. PHYS. DIRECTOR PHYS.									-0(
十	NAME (T)	rpe) James T	P. Hal	linan M. D.			ROST OF	in arminin a		R	ù
2	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)										(State)
	Burial	3/20/	57	Hillcrest				Cumberla			
2	4. FUNERAL DIRE	CTOR	KOY	. ADDRESS		1 25a. REC	D BY RECISTRA	R 25b. REG	ISTRAR'S S	ICNATURI	Ē
	John J.	Hafer Jr	7.330	Balto Ave.	Carr	mberland Mo	2 3 1967	gelie	reles!	Judge	٤.
				LIZE IN THE SECOND		TITACY FOR LOS AL		1 11		///	

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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
(to 100 c		E OF DEATH	12999								
and death	1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: a. STATE MARYLAND b. COUNTY A	Residence before admission								
ours after in by the Pages Itours after	b. CITY OR TOWN (if outside corporate limits, white RURAL and give nearest town) Cumbercand, LIFE	c. CITY OR TOWN (If outside corporate limits, write RURA Cumberland.	L and give nearest tow								
ted within 24 hours after completely filled in by the ve carbon papers. Pages 1 event, within 72 hours after	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL ¹	000 1 011 2 1 010	e. IS RESIDENC ON A FARM?								
within pletel carbon nt, wit	3. NAME DF DECEASED (Type or print) CATHERINE ELizabeth	WAHL 4. DATE Month DF DF DEATH , 03	Day Year 28 ₁₉ 67								
nd con	5. SEX FEMALE 6. COLOR OR RACE 7. MARRIED NEVER MARRIED TO DIVORCED DIVORCED	8. DATE OF BIRTH 03-29-1879 9. ACE (In years IFUNDE last) thday) Months yrs.									
e death certificate be executed within the attending physician and completely t permit. Then please remove carbon intion, or removal, and in any event, with	during king life, even if retired) Ret. Seamstress 10b. KIND OF BUSINESS OR INDUSTRY Pept. Store	11. BIRTHPLACE (County & State, or foreign country) 12. ALLEGANY COUNTY, MD.	CITIZEN OF WHAT COUNTRY? USA								
certificat iding phy Then p removal,	13. FATHER'S NAME Francis WAHL	14. MOTHER'S MAIDEN NAME MARY E. (BURKHart" (
eath ce attend ermit. on, or re	15. WAS DECEASE. EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) (Yes, no or unknown) (If yes give war or dates of service) 214-05-9507 SACRED HEART HOSPITAL										
quires that thing physician. en signed by the burial-transito burial-transito	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARD IAL PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARD IAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the DUE TO	INFARCTION ARTERIOSCLEROTIC CVD	INTERVAL BETWEEN ONSET AND DEATH 6 DAYS								
: The	underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT REL ASTHMATIC BRONCHITIS	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a	YES NO								
PHYSI the h this this detac	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, farm, lory, street, office bldg., etc.) (City or town) (Co	ounty) (State)								
TYAL OR ATTENI may be retaine RAL DIRECTOR. ", page 3 shoul be filed with the	21. I certify that (I) (this hospital) attended the deceased from 3-L7- 19 67, to 3-28- 19 67, that (I) (we) lass with the deceased alive on 3-28- 19 67, and that death occurred at 3:L5 M, from the causes and on the date stated above 22a. SIGNATURE 22a. SIGNATURE M.D. ATTENDING IXK MED. THYS. I 3-28-67 22c. PHYSICIAN'S WYAND F. DOERNER, JR., M.D. 414 N. MECHANIC STREET, CUMBERLAND, MD										
TO HOSPITA Page 4 me TO FUNERAL director, P	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER REMOVAL (Specify) 3/31/67 SS. Peter & 24. FUNERAL DIRECTOR ADDRESS	Paul Cem. 23d. LOCATION (City, town or comberland, All 25a. REC'D BY REGISTRAR 25b. REGISTRA	county) (State) Legany Md. R'S SIGNATURE								
VR A15 (4)	H. Wayne George Cumberland, Md.	DATE APR 3 1967 golian	les Judge								

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03008 CERTIFICATE OF DEATH I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY a. STATE Allegany the attending physician and completely filled in by the full sit permit. Then please remaye carban papers. Pages I matian, ar remayal, and in any event, within 72 hours after a Maryland Allegany MARYLAND requires that the death certificate be executed within 24 hours after b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURA, and give negrest tawn) Frostburg 10 I Frostburg 10 Days d. STREET ADDRESS IS RESIDENCE ON A FARM? Miners Hospital 282 East Main St YES 🗌 NO Y 3. NAME OF 4 DATE Month Day Year DECEASED (Type or print) Walters Flovd DEATH March Davton 9 AGE (In years last birthday) S SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH Manths Doys Hours WIDOWED DIVORCED Male White 10a JSUAL OCCUPATION (Give kind of work done 105 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Machinist (Retired) Celanese Corp Ohio II S A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME William Walters Amanda King IA SOCIAL SECURITY NO 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT (Yes, no, or unknown) (if yes give war or dates at service) 213-01-5952 Mrs. Edna E. Walters Frostburg. IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN burial-transit ONSET, AND DEATH Mulocan IMMEDIATE CAUSE (6) signed by DHE TO Conditions, if any, which gave nse ta immediate couse (a). DUE TO stating the underlying cause Page 4 may be retained by the hospital or attending D FUNERAL DIRECTOR: After this certificate has been detached far use as the te Dept. af Health prior ta last 19 WAS AUTOPS'
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO 20b DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Port II of Item 1B.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) 20c. TIME OF INJURY Month, Day, Year (State) factory, street, office blda, etc.) Not While of work at work 2]. I certify that (1) (this haspital) attended the deceased from \(\lambda \ saw the deceased glive an Will. 1967, and that death accurred at _____M, fram causes and an the date stated above. 220 SIGNATURE C 22b. DATE SIGNED STAFF PHYS 3.21.6 DIRECTOR . M D 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) LONACONING 23a. BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) Md Frostburg Memorial Park Frostburg 2Sq REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURE 24 JUNERAL DIRECTOR VR A15 (4) Milarles 2 1/66 Ito Ave Cumberland



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03009 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o COUNTY o STATE Allegany Allegany MARYLAND Maryland b CTY OR TOWN (If outside corporate I mits, write RURAL and give nearest town) c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY N 1b pup 45yrs. Cumberland Cumberland d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 33 Fifth Street 17 Humbird Street YES NO 😼 3 NAME OF 4 DATE with Middle DECEASED Clyde (Type or print) White DEATH March within With 5 SEX 6 COLOR OR RACE 9 AGE in years B DATE OF BIRTH IF UNDER YEAR IF JNDER 24 HRS 7 MARRIED NEVER MARRIED la pirthdoy) Months Dovs 0 Hours M WIDOWED DIVORCED June 16. 1907 1Do USUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign countr 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? gny Different Davis W. Va. Types 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME ⊑ John White File Frances Wolford IS WAS DECEASED EVER NUS ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) remayol. 214-05-6060 Mrs. Thelma Nines, Cumberland, Md. 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY Sudden DEATH Coronary Occlusion, left IMMEDIATE CAUSE (6) Ward certificate should cremation. DUE TO Thrombosis, Coronary Conditions, if ony, which gove rise to immediate couse (o), DUE TO storing the underlying couse 0 Sclerosis Coronary 0.5 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) WAS AUTOPS PERFORMED? YES A NO Cardiac Hypertrophy, left; Pulmonary Emphysema 2Do EXTERNAL CAUSE ₩AS 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) prior should PRIMARY Or CONTRIBUTING CAUSE OF DEATH 2Dc TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 20e PLACE OF INJURY (Home form 20f (City or fown) (County) (Stote) Hour o.m. foctory, street, office bldg, etc.] moy be retoined for your FUNERAL DIRECTOR: Poge of work 21. I certify that I took charge of the remains described above, held an Autopsy [X], Inquiry X, Inspection X., and in my opinion Natural causes XI. Accident . Suicide . Hamicide . death resulted fram: Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE funerol FO FUNERAL Heolth or DEPUTY MEDICAL EXAMINER **EXAMINER'S** Benedict Skitarelic, M.D. Address (Street city town, or county) Rt.9 Cumberland NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23d LOCATION (City or Town) March 12,1967 Hillcrest Burial Park Cumberland, Md. Allegany 2So. REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR ADDRESS. Scarpelli, Cumberland, Md. VR A15ME 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03010 FOR STAJE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) defoy 1, and 3 to Poge o. COUNTY Allegany b. COUNTY Allegany Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 16 write RURAL and give negreet town) Cumberland. e. IS RESIDENCE ON A FARM? YES NO PA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS hours Sacred Heart Hosp. 207 Greene St. Item 18. Give Poges 3. NAME OF First Middle 4 DATE Month Year DECEASED Paul Sterling Wood March 67 (Type or print) DEATH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthdoy) Months Hours Male White WIDOWED DIVORCED 1/25/06 event IDo. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT Textile Plant Cumberland, Md. COUNTSY? A. pages I in any pencil 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME by executed within Margaret L. Kaden J. Morgan Wood 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) or remayal, 214-07-4898 Miss Betty Wood 207 Greene St. Cumb. Md. 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: Intra-abdominal hemorrhage 495ETHAND PEATH IMMEDIATE CAUSE (o) certificate should writing the word cremotion, 4511 DUE TO Rupture of arteriosclerotic Aortic Aneurysm 45 mins. Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse buriol, o 19. WAS AUTOPS) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES X NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) ogent, prior PRIMARY I or CONTRIBUTING I CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) may be retained for your FUNERAL DIRECTOR: Page of work 21. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection X, Inquiry X ond in my opinion deoth resulted from: Notural couses X. Accident | Suicide Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL Rt. # 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Balto. Pike 10 DEPUTY MEDICAL EXAMINER IX 3/29/67 EXAMINER'S Benedict Skitarelic, Mi TO FUNE! Address (Street, city, town, or county Cumb NAME (Type) 23b. DATE THEREOF 23o. BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BULLAL (Specify) 4/1/67 SS. Peter & Paul Cemetery Cumberland. Alleganii 24. FUNERAL DIRECTOR VR AISME (\$) ocharles Cumberland, Md. 1967 Wayne George

416.77 . 20. 100 2 ALT USE ST A Large Market Large T The state of the s 48 7 . The second of THE THE THE PARTY AND APPLICATE APPLICATE AND APPLICATE APPLICATE AND AP 3M 3M 3M 3M . - 1 Alle and the second of the second second second THE A MESS SET OF Additional Conference of the C The Alexander Service Service

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 93011 requires that the death certificate be executed within 24 hours after death. 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH dea O. COUNTY ALLEGANY b. COUNTY a. STATE MARYLAND ALLEGANY MARYLAND event, within 72 hours after c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, DAYS CUMBERLAND. MD. d. STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) papers. 901 YALE ST. completely filled NO 50 Memorial Hospital 3. NAME OF First Middle Lost 4 DATE Year DECEASED ZAIS MARCH 1967 HOWARD W. (Type or print) DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH NEVER MARRIED lost birthdoy) WHITE Haurs MALE 1-23-05 duy WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY ease U.S.A. oud WESTERNPORT. MD. Carpenter 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, cremation, or removal, MAE PATRICK JOHN ZAIS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dotes of service) CUMBERLAND, MD. MEMORIAL HOSPITAL No 214-07-1103 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse par-tine for (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH burial-tronsit IMMEDIATE CAUSE (d) Canditians, if ony, which gave rise to immediate couse (o), DUE TO stoting the underlying couse Page 4 may be retained by the hospital or ottending for use as the 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES [NO FUNERAL DIRECTOR: After this certificate 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Haur o.m. Not While of work and that death accurred 81.5 that (1) (we) last 21. L certify that (1) (this haspital) attended the deceased fram : 05A M, from causes and an the date stated above. director, page 3 should should be filed with the saw the deseased alive an_ 220. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. MED. DIRECTOR 22d. ADDRESS 22 PHYSICIAN'S CENTRE ST., CUMBERLAND. MD. 122 S. DR. R.J. WILLIAMS NAME (Type) 23b. DATE THEREOF 23d. LOCATION (City or Town) 23g. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY (County) (State) BEMOVA (Specify) Cumberland Allegany Maryland 3/3/67 Sunset Memorial Park 0 25b. REGISTRAR'S SIGNATURE ADDRESS 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Ocharelan H. Lee Silcox Cumberland Maryland 21502

